	T = For State Registrar	State of Marylar		rtment of F		-	rgiene Reg. N. 2 () ()	1 30001
Physician	Decedent's Name (First, Middle, La     Randolph	T.		Ram	2017	2. Date of De Month	eath Day	3. Time of Death
/Medical Examiner	4a. Facility Name (If not institution, git St. Agnts Ho	alth Cart		4b. City, Town, or Balti	Location of Death		4c. County of	Death
Funeral Director		Sex 7. Age (In yrs. XXM 2□F 56	last birthday)_ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	rth ay, Year) 11 48	Birthplace (State or Foreign Country)      M D
with the Maryland to 28a-f show be radiffed at Director	10a. State 10b. County  MD NA		ty, Town or Loc					10d. Inside City Limits 1 Y Yes 2 □ No
Baltimore, Maryland 21215-0036 pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23a or 28a-1 show any injury or other treumatic event, the Medical Examination to indiffer at once.  To Be Completed by Funeral Director	10e. Street and Number  20 North Mona  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)  10th grade  17. Father's Name (First, Middle, Las.  William Ramse  19a. Informant's Name/Relationship  Regina Hender: 20a. Method of Disposition  Quirial 2 Cremation 3 C 4 Donation 5 Other (Speci	12. Was Decedent Ever in UArmed Forces?  1	16a. Decedor (Give kife. Decedor life. Deced	As Decedent of H Yes, specify Cuba  Yes, Specify Cuba  Yes, Specify Cuba  One of the specific	ation  18. Mother's Name  Ernesti  and Number or Run  Dnastery  Park 12/  By of Facility  H West	ing e (First, Middle ne Ki; al Route Numb Ave, Date	Various, Maiden Surname, Ser, City or Town, Single 20c. Location - C	A American Indian, White, etc.  Black ness/Industry  IS Jobs  Late, Zip Code)  Ore, Md 21229  Ity or Town, State
68760, children be executed by physician and se the buriat-transit as the buriat-transit edical Examiner	23a. Part 1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Disease or injury that initiated events resulting in death) Last	one cause on each line.	Supplies (guence of):		g, such as cardiac'd			Approximate Interval Between Onset and Death  4 Months 5
O. Box O. Box The death cert The attending The documents The death of the serious	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnation 1 Live birth 2 Feta 4 Pregnant at time of degree Unknown	ldeath 3□E	Ectopic pregnancy Other (specify)			23d. Date Month	,
ecords, P. law requires that the as been signed by 2 should be detailed by Phi	Part II. Other significant conditions  Dipple 465	contributing to death but not res	sulting in the und	derlying cause give	on in Part I.	23e. Did t		ute to the cause of death?
	Hyper fans.	con				24a. Was autor perfo 1 - Yes	psy prio	re autopsy findings available of to completion of cause of the 2 Ano
vision of Vita vision of Vita Attending Physicien: cleath. ector: Atten this certific by the tuneral director, y the funeral director.	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death 1  Natural 5 Pending investigation		ER/Outpatient 28b. Time of Injury	28c. Injury Work	26. Place of Death  T: 4 \( \text{Nursing Hoi} \) at ?  Yes 2 \( \text{No} \)	me 5 ☐ Resid	dence 6 Other	
Diversitied in Stilled	3 Suicide 6 Could not be determined	building, etc. (Specif				City or Tov	wn, State)	or Rural Route Number,
the pple	(Check only 2 Medicel Exer	nysicien: To the best of my knominer: On the basis of examina and manner stated.	tion and/or inve	estigation, in my op	inion, death occurr	ed at the time,	date and place, and 29d. Date signed (	d due to the cause(s)
To with To com	> Beneal H	4h				-	December	· 6,2004
State Registrar	30. Name and address of person who KOIN I SCALLO	completed cause of death (Item  1.65 LLLL) GOZ  1.04 32. Registrar's Signal	Cart	ports	nue B	se. I fine	on Man	- 6, 2004 Cyland 21225

Cephus Jimmy Rodgers Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend Amend item# 4B.23a.PIT.27.28a-f.perMF.G838.12/18/04 TT State of Maryland / Department of Health and Mental Hygiene 04-07866 RPD 1 - For State Registrer Reg. No 2 0 0 L Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** December 5, 2004 Rodgers Jimmy Cephus /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner NA 5701 Cedonia Avenue Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1♥M 2□F 212-56-3820 Yrs 53 Director 11-28-51 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits worle traumatic event, the Medical Examiner must be notified at Md. NA 1X Yes 2 □ No Baltimore Director or 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA Apt. A-7 21206 5701 Cedonia Avenue or Items 23a Completed by Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Item any injury or other traumatic svent, the Medical Examine 1 ☐ Yes 2 ☐ No If <del>Yes</del>, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: Black 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) University Hosp. State of Md. 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alston Christine Rodgers Cephus P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21206 5701 Cedonia Ave. Apt. A-1, Baltimore, Md. Wife Barbara Rodgers 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 12-10-04 Baltimore , Md. Baltimore Nat. Cem. 21202 22. Name and Address of Facility Baltimore, Md. 21. Signature of Funeral Service Licensee March F.H. East 1101 E. North Ave. lus 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a Narcotic Intoxication /Medical Due to for as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Inknown Cocaine Use Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? has page 2 certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6XXOther (Specify) At Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1X Yes 2 □ No P this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification; After 5 Pending investigation 1 Natural Found 1 ☐ Yes 2 🙀 No death. 2 Accident Director: 6 Could not be determined 12/5/2004 At hom 11 20 ee Pactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 5701 Cedonia Ave. 3 Suicide 4 🗌 Homicide Baltimore, MD. 24 hours a e Funeral I Found At Home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of partifier O.C.M.E. December 6, 2004

State Registrar So

31. Date filed (Month, Day, Year) DEC 0 9 2004

30-Name and address of person who completed cayse of

fdeath (Item 23a) (Type Pipi) Penn Street, Baltimore, Maryland 21201 OLLAK

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2004 39003 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** STANCIL 0:06 PM NATHAN Reember Z004 /Medical 4a. Eacility Name (If not institution, give street and number) 4c. County of Death City, Town, or Location of Death **Examiner** N/A MOCO If Under 24 Hrs. uane 7. Age (In yrs. last birthday) Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Hours 100M 20F 88 NC 237. 24.40 Yrs. Director 3.18 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show nerman be notified at Baltimore MD 1 ☐ Yes 2 No Baltimore Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10a, Street and Number 21207 2617 PUMEL Drive 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status the Medical Exactines 1 MYes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 Yes 2 No Specify: Specify: BLACK 3 Widowed 4 Divorced natural, 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. snt: if item 27 is marked other than ury or other traumatic event, tra Ms Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel WELDER Leth grade NI 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Nathan Stancil, Sr. Betty Dickens ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter Drive Baltimore MD 21257 Dullia R. Stanci 2617 Pumell 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 12.14-04 Department o Important: if any injury or once. Owings Milb, MD Garnson Forest \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signa are of Funeral Service Licens 23. Name and Address of Facility Funeral Services Valligh & Greens Funeral Services 5154 Baltimore Natl Pike Baltimore MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYUCARDITE Physician /Medical Due to (or as a consequence of) Examiner CORUNARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Examiner sician and burial-transit Due to (or as a consequence of): attending physician IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day ō in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 I Inknown á 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. The law requires 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe certificate 1 Yes 2PINO Division of Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 this 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death s after death. Certification: Injury 1 Natural 5 Pending investigation 2 🗌 No 1 Tyes 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide within 24 hours a Hospital 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 00051865

State Registrar

DHMH 17 Rev 1/2001

DEC 0.9 2004

MARLES

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1273

32. Registrar's Signature

**ORIGINAL** 

HUSDITHE BRETMORE

			Eor	State of Maryland /	Depar	tment of H	ealth and	Mental Hy	giene	
		1	For State Registrar		Certi	ificate of L	Death		Reg. No 200	4 39004
	Physicia		1. Decedent's Name (First, Middle, La		Sr			2. Date of Dea	ath Day Ye	ar 3. Time of Death
	/Medic	al -	John Christof 4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Do	12	4c. County of D	Doy II: DO PM
	Examin	er	Baltimore VA A			- 11	more		NIA	
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs. last b	birthday)	If Under 1 Year Months Days	If Under 24 H		th 9.	Birthplace (State or Foreign Country)
	Director	L	20 1 10 12 70	1 ½ × 2□ F 83	Yrs.			June28	3,1921 V	irginia
	land		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Loca	ation				10d. Inside City Limits
	Mary Ff she	ţ	MD Balt	timore		Essex				1 ☐ Yes 2 🔀 No
	th the	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	t Country?
	ath wi	rai	1256 Sugarwood		40.14	2122		(Casaita Vas as Na	USA 14 Baco	American Indian,
	Itams	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces?	13. W	as Decedent of Hi Yes, specify Cuba	n, Mexican, Pu	(Specify Yes or No lerto Rican, etc.)		Vhite, etc.
920	urs af	by	3 ☐ Widowed 4 ☐ Pivorced	1. ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	10	☐Yes 2[XXNo	Specify:		Spec <b>W</b> :h	ite
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itama 23a or 28e-f show the Medical Examinar must be notified at	Completed	15. Decedent's E (Specify only highest gr		Sa. Decede	ent's Usual Occupa ind of work done of O NOT use retired	ation during most of	working	16b. Kind of Busine	
121	within than than	mp	Elementary/Secondary (0-12)	College (1-4or 5+)		tender	,	ľ	MiddleRi	verInn
N	e filed withIn al Hygiene. I othar than vant, the Me	Be Cc	8th 17. Father's Name (First, Middle, Las	ŋ			18. Mother's N	Name (First, Middle,	, Maiden Sumame)	
/lan	uld be Mental rrked c	To B	unknown	_			unk	nown		
Maryland	2 should and Missing mark		19a. Informant's Name/Relationship	. ,, . ,					er, City or Town, Sta	
	iges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hyglene. If it itam 27 is marked other than "natural, or itama 23a or 28e-f show or other treumatic event, the Medical Examinat must be notified at		Jim Wood /nep	20b. Place	of Disposi	ition (Name of		ircle Ba	altimore 20c. Location - City	
nor	ages ent of it: if it y or o	li	1 Surial 2 Cremation 3 ( '4 Donation 5 Other (Special	THemoval from State   Hol	lyHi 1yHi	atory or other place 11Cemet	ery 1	2/10/04	Baltimo	re MD
Baltimore,	permit. Pages of Department of Himportant: If its any injury or of once.		21. Signature of Funeral Service Lice	The second secon	22.	Name and Addres	ss of Facility	Connelly	vFuneral	HomeofEssex
0	88188		1. Peru	Connelly		300	Mace	AVO B	altimore	MD 21221
			23a. Part 1. Enter the disease, or or shock, or heart failure. List on	polications that caused the death D one cause on each line.	o not ente	r the mode of dyin	g, such as care	diac or respiratory a	rrest,	Approximate Interval Between Onset and Death
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	Examiner	П		b. Atherosclera	otic	cardio	vascul	lar dise	alse	25 years
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1.	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Congestive h	ce of):	+ fail	we	1	/ MY	2 months
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68760	# × #			9.				TO ROVED BY		
Вох	death certifical e attending phy of for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal dea		Ectopic pregnancy	CERTIFIC	*** /	23d. Date of Month	f delivery Day Year
0.	0 0 0	ysici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of death 9□Unknown	1 5 🗌	Other (specify)		1		,
<u>α</u>	that the		Part II. Other significant conditions	contributing to death but not resultin	g in the un	derlying cause giv	en in Part I.	23e. Did t	tobacco use contribu	te to the cause of death?
rds	quires l	ed by	Left ventricula	r dysfunction	1,0	ronary	arter	y 10	Yes 2 No 3[	Probably 4 Unknown
Records,	The law requires that the ate has been signed by the page 2 should be detache	Completed	pseudoaneury	ir dystunction in Pleural ef	Fusi	on, hy	perlen	SIDM 24a. Was	psy prior	e autopsy findings available r to completion of cause of
H		Com					,	perfo 1 ☐ Yes	ormed? deat 2 No 1	th? Yes 2□ No
Vital	Physician: The ribis certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	10-111	3 DOA Oth	0.00	Death Check onl	one idence 6 □Other (	Canaidal
of	ding Phys h. After this funeral di	n: To	1 X Yes 2 □ No 27. Manner of Death	The state of the s	Outpatient	3 DOA  28c. Injun	4   Idai Sii			puss graft
sion	andin sath. or: Aft he fun	atio	1 □Natural 5 □ Pending  2 ■ Accident investigati	on 0/22/04 m	Injury UKNOU	NA 1 1	Yes 2 No	during	ardiac rat	The terization
Division	i or Attand after death Director: A	Certification;	3 Suicide 6 Could not 4 Homicide determine	building, etc. (Specify)	, larm, stre		-51 - 1	City or To	wn, State)	or Rural Route Number,
	spitei ours a narai L		29a. Certifier 1 ☐ Certifying F	hysician: To the best of my knowled	dge, death	occurred at the tir	ne, date and p	lace, and due to the	cause(s) and manne	Smore MD 21201_ er as stated.
	To the Hospitei or Attanding within 24 hours after death. To the Funarai Director: After completely filled in by the funer	Medical	(Check only 2 Medical Extrone)	aminer: On the basis of examination and manner stated.	and/or inv	estigation, in my o	pinion, death o	occurred at the time,	date and place, and	due to the cause(s)
	To the	Ž	29b. Signature and title of certifier	0 0 4.		29c. Licens			29d. Date signed (A	
•			Thea	26 Fratt			601		vecembe	r 6, 2004
10			30. Name and address of person wh Alexandra Pr	o completed cause of death (Item 23			Baltin	we MI	21201	
¥	St	ate	31. Date tiled (Month, Day, Year)	32. jegistrar's Signature		- O1.				
	Regist	rar	DEC 0 9 2	1994 Malera	1	9402				

		1	For	Department of Health and Me Certificate of Death	ntal Hygiens	004 39005
			Decedent's Name (First, Middle, Last)	2.	Date of Death Month Day	3. Time of Death
	• Physicia		Colleen	Scott D	ecember 3	6 2004 0900 A M
-S	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. 0	County of Death
	. 1	B 10	Johns Hopkins Hospital	Baltimore		NA
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bin	Months Days Hours Min.	Date of Birth (Month, Day, Year) 3-6-39	9. Birthplace (State or Foreign Country)
	Director		219-26-7572	Yrs.	3-6-39	Md.
	p	-	Usual Residence of Decedent  10a, State 10b. County 10c. City, Town	n or Location		10d. Inside City Limits
	sho	5		Baltimore		1 XYes 2 ☐ No
	28a-1	Director	10e. Street and Number	10f. Zip Code	10g. Citiz	en of What Country?
	With With	0	1510 Pentwood Rd.	21239		USA
	ns 23	era	11 Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Specif		4. Race - American Indian,
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mertal Hygiene. If itam 27 is marked othar then "natural" or Itams 23s or 28s-f show or other traumatic event. The Madical Exercities must be notilised at	by Funerai	Amed Forces?  1 Never Married 2 Married  1 Yes 2 No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto Ric		Black, White, etc.  Specify: Black
21215-0036	2 hou atura	ted		Decedent's Usual Occupation (Give kind of work done during most of working		nd of Business/Industry
215	hin 7	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)		
7	d with	Com		Educational Asst.		timore City Schools
b	al Hygi al Othar vant, I	Be (	17. Father's Name (First, Middle, Last)	·	First, Middle, Maiden :	Sumame)
<u> a</u>	2 should be filed within and Mental Hygiene. is marked othar then aumatic evant. Ite Ma	10	Melvin James	Marguer		Johnson
Maryland	2 sho		, , , , ,	. Mailing Address (Street and Number or Rural F		
<u>~</u>	and lealth m 27 her t			1306 Windemere Ave., B	Baltimore,	Md. 21218 cation - City or Town, State
0	ges 1 t of h If ita or of		1 XBurial 2 Cremation 3 Removal from State	imore Cem. 12-10-		timore, Md.
Baltimore,	t. Pa rtmer rtent: njury		4 □ Ponation 5 □ Other (Specify)  21. Sinaure of Funeral Service Licensee/	22. Name and Address of Facility	Baltimor	
Ba	permit. Pages 1 and 2 Department of Health a Importent: If itam 27 is any injury or other tra once.	1 1	Jesigh R. Waltuch	March F.H. East	1101 E. No	orth Ave.
	,		23a Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardiac or i	espiratory arrest,	Approximate Interval Between Onset and Death
	Pnysician		Immediate Cause (Final diagnose or condition Septice Sh	ock serendary to	liver f	
	/Medical		re Miting in death)  Due to (or as a consequence	of):		i V
	Examiner		Sequentially list conditions, b. Automan			1/2 years
	D ==	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	of):		more than
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9 x	ding	/Me	IF FEMALE: 23c, If yes, outcome of pregnancy		2	23d. Date of delivery
Вох	eath certific attending p I for use as I	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death	n 3 □Ectopic pregnancy 5 □ Other (specify)		Month Day Year
o.	that the de ed by the a detached	ysi	1 ☐ Yes 2 No 9 ☐ Unknown 9 ☐ Unknown		and the second s	
<u>α</u>	res that igned b be deta		Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco u	se contribute to the cause of death?
ds	quires n sign	d by			1 Yes 2	□ No 3 □ Probably 4 □Unknown
Records,	w require been signatured should b	Completed			24a. Was an	24b. Were autopsy findings available prior to completion of cause of
Re	he lav e has age 2	шс			autopsy performed? 1 ☐ Yes 2 No	death?
Vital		Q)	25. Was case referred to medical	26. Place of Death /	· · · · · · · · · · · · · · · · · · ·	
>	Physician: this certificatal ral director.	To B	examiner? , Heavital	utpatient 3 DOA Other: 4 Nursing Home	e 5 Residence 6	6 □Other (Specify)
of	₹ ± ë		27. Manner of Death 28a. Date of Injury 28b.	Time of 28c. Injury at 28 Injury Work?	d. Describe how injury	y occurred
0	E & S =	atio	2 Accident investigation	M 1 Yes 2 No		
Division	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, f building, etc. (Specify)	arm, street, factory, office	St. Location (Street and City or Town, State)	d Number or Rural Route Number, )
	spital nours narel		29a. Certifier 1 Certifying Physician: To the best of my knowledge	ge, death occurred at the time, date and place, ar	nd due to the cause(s)	and manner as stated.
	na Ho n 24 t na Fui sletely	Medicai	(Check only one)  2 Medical Examiner: On the basis of examination a and manner stated.	nd/or investigation, in my opinion, death occurred	d at the time, date and	place, and due to the cause(s)
	To the within To the comp	ž	29b. Signature and title of certifier	29c. License number	~	te signed (Month, Day, Year)
			Jell MD	KE5-000		ember S, 2004
	10		30. Name and address of person who completed cause of death (Item 23a)		range	21007
	1		31 Date filed (Month, Day, Year) 32. Registrar's Signature	t Baltimore 1	Maryland	7198.
1	St Regist	ate	31. Date filed (Month, Day, Year)  DEC 0 9 2004	/		
	negisi	1 21		BOOK /		

04-07852 Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. Unpend 11em#23a, PII, 27, perME, G838, 12/18/04 TI State of Maryland / Department of Health and Mental Hygiene ROBERT F SILVA JHM 1 - For State Registrar Certificate of Death Reg. No 2 1 1 1. Decedent's Name (First, Middle, Last) 2. Date of Death DECEMBER 5, 2004 **Physician** 2:25 P ROBERT FRANK SILVA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 9900 MALLARD DR LAUREL PRINCE GEORGES CO If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5 Social Security Number 6 Say 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Days 1□xM 2□ F Yrs. 7/25/1942 Director 004-44-0700 62 MAINE Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD PRINCE GEORGE LAUREL the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 9900 MALLARD DRIVE 20708 USA 238 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. within 72 hours after 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed . 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) The Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ANALYST NSA other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be EVELYN T. RICHARD ERNEST F. SILVA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 118 BENNETT LOT ROAD, SOUTH BERWICK, MAINE 03908 RICHARD BONCI / COUSIN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ō 1 Burial 2 Cremation 3 Removal from State Department o Importent: If any injury or once. 6 \* 4 ☐ Donation 5 ☐ Other (Specify) BALT/WASH CREMATORY 12/8/2004 LAUREL, MARYLAND 22. Name and Address of Facility FLECK FUNERAL HOME, INC. 21 Sonature of Funeral Service Licensee 7601 SANDY SPRING ROAD, LAUREL, MD 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Atherosclerotic Cardiovascular Disease /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): the burial-Box 68760, Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 Cher (specify) 4 Pregnant at time of death of Vital Records, P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Chronic Alcohol Abuse 24b. Were autopsy findings available prior to completion of cause of death?

1 2 8 2 No 24a. Was an page 2 autopsy performed? 1 Yes 2 \( \int \) 2 No 25. Was case referred to medical examiner?
1 🔏 Yes 2 🗆 No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) SCENE 2 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification:

hours after death.

Ineral Director: After this

y filled in by the funeral di Division within 24 hours a To the Funeral I the

1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O C M E

DECEMBER 6, 2004

State Registrar

Medicai

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 PENN STREET, BALTIMORE, MARYLAND, 21201 MR. U 31. Date filed (Month, Day, Year)
DEC 0 9 2004

32. Registrar's Signature Elya.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 200L 39007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Year **Physician** Schisler 24 2004 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Name (If not institution, give streat and number) Examiner Sykesulle, MD arrol Home Lnc TGE Quest 7. Age (In yrs. lest birthdey) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day. Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 12 M 2 F 16:20. Maryland Director Usuel Residence of Decedent with the Marylend 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County ahow r than "natural", or items 23a or 28a-f aho the Mexical Examiner must be notified a MD Carrol1 Sykesville Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1442 Buckhorn Road 21784 USA Pages 1 and 2 should be filed within 72 hours after death venent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or items 23 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 143-45 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Stetus Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: white δ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk College (1-4or 5+) Elementary/Secondary (0-12) 12 machinest 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Be John Charles Schisler Clara Elizabeth Luby 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Golden Age Guest Home 1442 Buckhorn Road Sykesville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition = 5 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from State Department 4 Donation 5 ☐ Other (Specify) Signature of Euneral Service Licensee Ronald S. Wade, 22. Name and Address of Facility Dixector State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner flul Mego. rances sician and buniel-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): P.O. Box 68760. Due to (or as e consequence of): 23b. Did tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records. Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? 1 Yas 2 No 1 ☐ Yes 2 1 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Naturel 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 20806 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ELDORSBURG MD LURNES TATRICK 1000

DHMH 16 Rev 6/95

State Registrar

31. Date filed (Month, Day, Year)

DEC 0 8 2004

32. Registrar's Signature

ysici		1. Decedent's Name (First, Middle, Last)	&10g PET FH G838 12	rtificate of Death 2/09/04 JH	2. Date of Death	No.	3 9 0 0 8
COLUMN TWO	an	YUDICE	MARSHA	STUCK	DECEMBER	3, 20°04	12:20 P <sup>M</sup>
Medic camin	_	4a. Facility Name (If not institution, give	treet and number)	4b. City, Town, or Location of Death		4c. County of Deat	
.,		3211 HATTON ROAD  5. Social Security Number 6. Sex	7. Age (In yrs. last birthday,	BALTIMORI ) If Under 1 Year   If Under 24 Hrs.	8 Date of Birth	9. Birti	BALTIMORE hplace (State or Foreign
eral			M 2 F UNKNOWN Yrs.	Months Days Hours Min.	<b>UNKNOW</b>	(ear) Co	UNKNOWN
88		Usual Residence of Decedent  10a, State 10b, County	10c. City, Town or L	ocation			10d. Inside City Limits
180	jo		TIMORE BALTI	MORE			1 ☐ Yes 2 ☐ No
Examiner must be notified at	lrec	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Co	
Mark	rai	3211 HATTON ROAD		21208		14. Race - Ame	UNKNOWN
	Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 M No	Was Decedent of Hispanic Origin? (Silf Yes, specify Cuban, Mexican, Puert	pecity Yes or No- o Rican, etc.)	Black, White	e, etc.
	þ	3 ☐ Widowed 4 M Divorced	1 ☐ Yes 2 ☑ No If Yes, Give ☑ Year or Dates:	1 ☐ Yes 2 🌠 No Specify:		Specify:	WHITE
	Completed	15. Decedent's Edu (Specify only highest grade	e completed) (Give	edent's Usual Occupation e kind of work done during most of wor DO NOT use retired)	rking	8b. Kind of Business/	Industry
	фшс	Elementary/Secondary (0-12) UNKNOWN	College (1-4or 5+) TEAC		1	MUSIC	
	BeC	17. Father's Name (First, Middle, Last)			ne (First, Middle, Ma	riden Sumame)	
	To		AYMOND STU				ARRASH
		19a. Informant's Name/Relationship (Ty  LAWRENCE BARRASH		ling Address (Street and Number or Ru OLD POST DRIVE #			
		20a. Method of Disposition	20b. Place of Disp			c. Location - City or	
,		1 X Burial 2 ☐ Cremation 3 ☐ F 14 ☐ Donation 5 ☐ Other (Specify)	lemoval from State		06/2004	ROSEDALE	, MD
once.		21. Signature of Mineral Service Licens		22. Name and Address of Facility SO			
a	П	Jen Man		900 REISTERSTOWN			MD 21208 Approximate
			ications that caused the death. Do not en ne cause on each line.  Arterioscleotic	aliana las N		,	Interval Between Onset and Death
ian cal		Immediate Cladse (Final disease or condition resulting in death)	Due to (or as a consequence of):	William C	126426		Sorrans
ier							
	9	Sequentially list conditions,	Due to (or as a consequence of):				
	늍	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):				
181-1181	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last					
the burial-tran	cal	that initiated events	Due to (or as a consequence of):				
se as the burial-tran	cal	resulting in death) Last	Due to (or as a consequence of):			23d. Date of de	livery
	cal	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	Due to (or as a consequence of):  Due to (or as a consequence of):  d.  23c. If yes, outcome of pregnancy 1	□Ectopic pregnancy		23d. Date of del Month	livery Day Year
1011 101 101 101 101 101 101 101 101 10	cal	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	Due to (or as a consequence of):  Due to (or as a consequence of):  d.  23c. If yes, outcome of pregnancy 1	Other (specify)		Month	Day Year
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nould be	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown  Part II. Other significant conditions co	Due to (or as a consequence of):  Due to (or as a consequence of):  d.  23c. If yes, outcome of pregnancy 1	Other (specify)underlying cause given in Part I.	1 ☐ Yes 24a. Was an autopsy performe	Month  2 No 3 Pr  24b. Were au prior to death? 1 Yes	Day Year  the cause of death?  robably 4 Unknown  utopsy findings available completion of cause of
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director, page 2 should be	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of):  Pregnant 2 □ Fetel death 3 4 □ Pregnant at time of death 5 9 □ Unknown  Dunknown  All Pregnant at time of death 5 9 □ Unknown  Dunknown  Dunkn	underlying cause given in Part I.  26. Place of Desent 3 DOA Cther: 4 Nursing Hof 28c. Injury at Work?  M 1 Yes 2 No	24a. Was an autopsy performs 1  Yes 24ath (Check only one) 28d. Describe how	Month  2 No 3 Pr  24b. Were at prior to death? No 1 Yes  ce 6 Other (Spering occurred)	Day Year  the cause of death?  robably 4 Unknown  utopsy findings available completion of cause of
in by the funeral director, page 2 should be	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of):  Page 12  Due to (or as a consequence of):  Due to (or as a consequence of)	underlying cause given in Part I.  26. Place of Decent 3 DOA  Other: 4 Nursing Hof 28c. Injury at Work?  M 1 Yes 2 No  street, factory, office	24a. Was an autopsy performs  1 Yes  24a. Was an autopsy performs  1 Yes  25 Residen  28d. Describe how  28f. Location (Stree City or Town,	Month  2 No 3 Pr  24b. Were at prior to death? 1 Yes  Ce 6 Other (Spe vinjury occurred)  State)	Day Year  to the cause of death?  robably 4 Unknown  utopsy findings available completion of cause of sectify)  ural Route Number,
director, page 2 should be	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions color examiner? 1  Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	Due to (or as a consequence of):  Petel death 3 4   Pregnant at time of death 5 9   Unknown  Ontributing to death but not resulting in the string in the least of the string in	underlying cause given in Part I.  26. Place of Decent 3 DOA  Other: 4 Nursing Hof 28c. Injury at Work?  M 1 Yes 2 No  street, factory, office	24a. Was an autopsy performs  1 Yes  24a. Was an autopsy performs 1 Yes  25 Residen  28d. Describe how  28f. Location (Stre City or Town, e, and due to the caurred at the time, dat	Month  2 No 3 Pr  24b. Were at prior to death? 1 Yes  Ce 6 Other (Spe vinjury occurred)  State)	Day Year  of the cause of death?  robably 4 Unknown  utopsy findings available completion of cause of society)  ural Route Number,  s stated.  a to the cause(s)
in by the funeral director, page 2 should be	dical Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of):  Page 12  Due to (or as a consequence of):  Due to (or as a consequence of)	underlying cause given in Part I.  26. Place of Decent 3 DOA Other: 4 Nursing For 28c. Injury at Work? M 1 Yes 2 No street, factory, office  ath occurred at the time, date and place investigation, in my opinion, death occurred at the time, date and place investigation, in my opinion, death occurred at the time, date and place investigation, in my opinion, death occurred at the time, date and place investigation, in my opinion, death occurred at the time, date and place investigation, in my opinion, death occurred at the time, date and place investigation, in my opinion, death occurred at the time, date and place investigation, in my opinion, death occurred at the time, date and place investigation, in my opinion, death occurred at the time, date and place investigation, in my opinion, death occurred at the time, date and place investigation, in my opinion, death occurred at the time, date and place investigation, in my opinion, death occurred at the time, date and place investigation, in my opinion, death occurred at the time, date and place investigation, in my opinion, death occurred at the time, date and place investigation, in my opinion, death occurred at the time, date and place investigation, in my opinion, death occurred at the time, date and place investigation, in my opinion, death occurred at the time, date and place investigation, in my opinion, death occurred at the time, date and place investigation in the time, date and place in the time.	24a. Was an autopsy performs  1 Yes  24a. Was an autopsy performs  1 Yes  25 Amount of the caurred at the time, dat  28d. Describe how  28f. Location (Stre City or Town,	Month  2 No 3 Pr  24b. Were at prior to death? 1 Yes  No 1 Yes  Ce 6 Other (Spering to coursed)  The stand Number or Research and Number and the stand due to and place, and due to Date signed (Month of the stand Number)	Day Year  to the cause of death?  robably 4 Unknown  utopsy findings available completion of cause of sectify)  ural Route Number,  s stated. a to the cause(s)
to the furnities by the funeral director, page 2 should be detached for use as the burial-transit	dical Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of):  Due to	underlying cause given in Part I.  26. Place of Desent 3 DOA Other: 4 Nursing Hof 28c. Injury at Work? M 1 Yes 2 No street, factory, office  ath occurred at the time, date and place investigation, in my opinion, death occurred to the time of the	24a. Was an autopsy performs  1 Yes  24a. Was an autopsy performs  1 Yes  25ath (Check only one)  28d. Describe how  28f. Location (Sire City or Town,  28d. and due to the caurred at the time, dat	Month  2 No 3 Pr  24b. Were at prior to death? No 1 Yes  ce 6 Other (Spering of the content of t	Day Year  to the cause of death?  robably 4 Unknown  utopsy findings available completion of cause of sectify)  ural Route Number,  s stated. a to the cause(s)

XINE	TILIMA	AN .	State of Maryland / Der 1- State Unpend Item 23a,27,28a-f per me	partment of Health and M G838 12-14-04 tas prifficate of Death	ental Hygie	erze 0 0 4	39009
			1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici: /Medic		Maxine	Tillman	NOV. 2	5, 2004 Year	0220 A <sup>M</sup>
0	Examin		4a. Facility Name (If not institution, give street and number) MARYLAND GENERAL HOSPITAL	4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death	
5	Funeral Director		5. Social Security Number  218-58-2877  6. Sex 1 M X F 7. Age (In yrs. last birthday 1 or 1 o	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day )	9. Birth	place (State or Foreign ntry) IA
	ow II		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or I	Location			10d. Inside City Limits
:	death with the Maryland ms 23a or 28a-f show r.must Le rodiffed at	tor	MD NA Baltim	ore			1 X Yes 2 ☐ No
	or 284	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Cou	intry?
	ath w		2515 Salem Street	21217		U.S.A.	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Maghit and Maralla Hygiens. Department of Maghit and Maralla Hygiens and used 1 fem 23a or 28a-f show important: It flam 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be routified at once.	by Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No — If Yes, Give	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I 1 ☐ Yes 2 ☑ No Specify:	Rican, etc.)	Black, White Specify:	, etc.
9	tural	ed b		edent's Usual Occupation	16	B J 6b. Kind of Business/Ir	Lack
215	hin 72 In "ne Wedis	plet	(Specify only highest grade completed) (Giv	e kind of work done during most of working DO NOT use retired)			,
21,	ed with	Completed	12th grade na D	isabled		Disabl	ed
Maryland 21215-0036	be file	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name		aiden Sumame)	
<u>S</u>	d Men narke	2	Joseph Robinson  19a. Informant's Name/Relationship (Type, Print)  19b. Ma:	Elaine ling Address (Street and Number or Rura		City or Town State 7	n Code)
N N	d 2 sl th an th an traur traur			5 Salèm St. Balt			
ē,	t Heal		20a Method of Disposition 20b. Place of Disp			Oc. Location - City or T	
E O	Pages ent of nt: If I		1   Hurial 2 XI Cremation 3   Hemoval from State !	rematory Inc. 12	2/6/04 I	Baltimore	e, Md
Baltimore,	permit. Departm Importa any inju			22. Name and Address of Facility March F/H West			
ω_	8858		John D. Johnson	4300 Wabash Ave.	Baltin	more, Md	21217
			23a. Part. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac o	r respiratory arres	st,	Approximate Interval Between Onset and Death
	nysician		Immediate Cause (Final disease or condition resulting in death)  Cocaine Intoxicat	ion			Chief and Doam
	/Medical Examiner		Due to (or as a consequence of):				
	ad sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury)				
	ate be executed hysician and the burial-transit	Examiner	that initiated events resulting in death) Last   c				
8760,	e be e /siciar e buris	dlcal E	d				
9	tiffic 19 p	Medi	IFFCHAIC.			•	
Вох	ires that the death certifics signed by the attending pl d be detached for use as t	Physiclan/Me		□Ectopic pregnancy		23d. Date of deliv	ery Day Year
	0 0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown 5	Other (specify)			
P.O.	requires that the reen signed by th hould be detache		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ds	quires n sign lld be	d by			1 🗆 Yes	2 <b>/⊠_N</b> o 3 □ Pro	bably 4 Unknown
000		Completed			24a. Was an	24b. Were aut	opsy findings available
Ä	The law ate has b page 2 s	mo:			autopsy performe 1 Xes 2	ed?	2 No
/ita	cian: ertific ector,	Be (	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)	)	
of \	Physic this call dire	P	1X Yes 2 No Hospital: XInpatient 2 ☐ ER/Outpati			ice 6 □Other (Speci v injury occurred <b>uni</b>	
uo	ding I	tlon	27. Manner of Death 1 □ Natural 2 □ Accident investigation 2 □ Accident investigation 11 − 2		do. Describe now	Injury occurred time	
Division of Vital Records,	Atten deat octor:	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm,	1	28f. Location (Stre	et and Number or Bur	al Route Number, alem Street
ē	al or /	Serti	4 Homicide Getermined building, etc. (Specify)  Residence	Ba	altimore,	State) 2010 Sa , Maryland	21217
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, de- and manner stated.				
	To the vithir comp	Me	29b. Signature and title of certifier	29c. License number O.C.M.E	290	d. Date signed (Month, NOV • 27 •	Day, Year) 2004
			30. Name and address of person who complete is use of death (Item 23a) (Typ		Me - 3	a 21201	-
	- C4-		S. Registratis Signature 131. Date filed (Mooth, Ray, Year) 10.	Street, Baltimore,	, mary Lar	K1 21201	
	Sta Registi		DEC 0 9 Z004	sporks			

			For State Registrar	State of M	Maryland / Dep Co	partment of He <i>rtificate of L</i>		, ,	iene 004	39010
			Decedent's Name (First, Middle	e, Last)				2. Date of Deat	h	3. Time of Death
	hysicia Medic		Alice	L.	Th	urston		Decembe:	r 2, 2004	4:00P <sup>M</sup>
	xamin		4a. Facility Name (If not institution	, give street and numbe	ər)	4b. City, Town, or	Location of Death	1	4c. County of Deal	
			Riverview Nurs			Essex	Millodov (Millo	T =	Baltimo	
	neral ector		5. Social Security Number  231–30–2830	6. Sex 1 ☐ M 2 ☑ F	Age (In yrs. last birthda 92 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, February	9,1912 V	hplace (State or Foreign ountry)
land			Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
Mary	Led	to	MD Balt	imore	Dunda	lk				1 ☐ Yes 2X No
h the	700	Funeral Director	10e. Street and Number			10f. Zip Code		10	0g. Citizen of What Co	ountry?
th wil	41	ai D	8106 Plaza Driv	e		2122	.2		USA	
or dea	BELL III	nue	11. Marital Status	12. Was Deceder Armed Force		<ol> <li>Was Decedent of Hi If Yes, specify Cuba</li> </ol>	spanic Origin? (S n, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	
s afte	- j	by F	1 ☐ Never Married 2 ☐ Marr 3 ☑ Widowed 4 ☐ Divorced	ied 1 □ Yes 2] If Yes, Give Year or Date:	_	1 ☐ Yes 2 No	Specify:		Specify: Wh	ite
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.	E E	edk	15. Deceden	t's Education	16a. Dec	cedent's Usual Occupa	ation		16b. Kind of Business	
nin 72	Wald	piet	(Specify only highes Elementary/Secondary (0-12)	st grade completed)  College (1-4c	life	ve kind of work done o . DO NOT use retired,	during most of wor )	king		•
d with	1	Completed	7 years	3535 (15		ousewife			Own Home	
tal Hy	event	Be	17. Father's Name (First, Middle,	Last)			18. Mother's Nan	ne (First, Middle, M	Maiden Sumame)	
ould Men	narke	၉	Emmitt Simms					Brooks		
12 sh h and	If item 2/ is marked other than "natural, or riems 439 or 406-1 and or other traumatic event, the Mudical Examiner must be notified at		19a. Informant's Name/Relations						, City or Town, State, 2	Zip Code)
1 and Health	Important: If Nem 27 Is any injury or other tra once.		Peggy Sue Campb 20a. Method of Disposition	<u>ell Daug</u> h	20b. Place of Dis	5 Smith Dr position (Name of			2   222 20c. Location - City or	Town, State
Pages nent of h	yoro		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S			rematory or other place on Cemetery	7 '	mber	Dundalle Mal	
nit. P	injur B.	l i	21. Signature of Fugera//Service		00	22. Name and Addres			Dundalk,Md undalk,P.A	
permit. Departn	any ir		(by thory	C. Cor	relly	7110 Solle	uneral H ers Point	iome Oi D : Road, D	undalk,P.A undalk,Md.	21222
/Me	ician dical niner	_	23a. Part 1. Enter the disease of shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a. Bilata Due to (or a	eral Klez as a consequence of):		G, such as cardiac		est,	Approximate Interval Between Onset and Death
The law requires that the death certificate be executed	physicien and s the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Einter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С	as a consequence of): as a consequence of):					
the death certif	been signed by the attending p should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		a 2 ☐ Fetal death : t at time of death :	3 □Ectopic pregnancy 5 □ Other (specify)	9.		23d. Date of del Month	ivery Day Year
s that	ned b a deta	by Ph	Part II. Dther significant condition	1.		underlying cause give	en in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
w requires t	n sign	ed b	Atrial Fit	orillation:	5			1 □ Ye	es 20No 3□Pr	obably 4 Unknown
The law re	certificate has bee rector, page 2 sho	Completed						24a. Was at autops perform	ned? prior to death?	utopsy findings available completion of cause of
cian:	ctor, p	BeC	25. Was case referred to medica examiner?_	1			26. Place of Dea	ith (Check only on		
Phyaic	this ce al dire	10	1 Yes 2 No	Hospital: 1 🗆 Inpa			inursing H		ence 6 Other (Spe	cify)
anding P	or: Atter to	ation;	27. Manner of Death  1 Natural 5 Pendir 2 Accident investi	gation	njury 28b. Time Day Year) Injur	y Work	/ at <br Yes 2 □ No	28d. Describe ho	ow injury occurred	
tel or Attending	al Directi ed in by ti	Certification:	3 Suicide 6 Could 4 Homicide determ	nined 286. Place of	Injury - At home, farm, etc. (Specify)	street, factory, office		28f. Location (St. City or Town	reet and Number or Ru n, State)	ural Route Number,
lds	# <b>#</b>	edical	(Check only 2 Medicel	ng Physicien: To the be Exeminer: On the basis and manner	s of examination and/or					
he Ho	ne Fur pietely	ed	one)							
To the Hospitel or Attending Physician: within 24 hours after death.	To the Funeral Director: Attenthis certificate has completely filled in by the funeral director, page 2	Med	29b. Signature and title of certifie	or C		29c. License			9d. Date signed (Mont	
To the Ho within 24 h		Med		won,	MD	056	number 979		9d. Date signed (Mont	
To the Ho within 24 h	To the Fur	Med		who completed cause of	MD of death (Item 23a) (Typ 5 Og kwbb	<b>556</b>	979		1 1	104

DHMH 17 Rev 1/2001

Registrar

DEC 0 9 2004 June 15 Aprelle

ORIGINAL

			For State Registrar	State	of Marylar				ealth a Death	ind Me	•	giene Rag. No	200	) 4	391	nıı
			Decedent's Name (First, Middle	, Last)							2. Date of De.	ath Da	v Y	'ear	3. Time of	Death
	Physicia /Medic		Jewell 7	Taylor							Decemb	er 2	200	04	9:20	) a <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution				,		Location o	f Death		. 4c.	. County of			
			Randolph Hills 5. Social Security Number	Nursing 6. Sex	Home 7. Age (In yrs.	last birthday)	If Unde	heato r 1 Year	If Under 2		8. Date of Birt	th	9	Egom Birthpl	ace (State o	r Foreign
	Funeral Director		240-14-7587	1 □ M 2 □ F	86	Yrs.	Months	Days	Hours	Min.	(Month, Da May 16	y, Year)		Count	h Caro	
	P _		Usual Residence of Decedent  10a State 10b County		10a Ci	ty. Town or Lo	antion				-				d. Inside Cit	
	show	2	,		100. 01	Wheato									1. Yes	
	the M	ecto	MD Monts  10e. Street and Number	gomery		wheat		p Code				10g. Cit	izen of Wh	at Count	41	
	3a or	<u>a</u>	4011 Randolph	Road				2090	01			Ur	nited	Sta	tes	
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show lis marked other than "natural", or Items 23a or 28a-f show reumatic event, the Medical Exercity or Items.	Funeral Director	11. Marital Status	12. Was De Armed F	cedent Ever in U	I.S. 13.	Was Dece	dent of Hi	ispanic Orig	gin? (Spec	cify Yes or No Rican, etc.)	-	14. Race - Black.	America White, e		
0	or Ita	by Fu	1 Never Married 2 Married	ied 1 ☐ Yes If Yes, G	2 ∏No Sive X		1 🗆 Yes		Specify:				Specify:		white	
2-003g	hours tural'		3 ☐ Widowed 4 ☐ Divorced	Year or	Dates:	16a, Dece	dent's Usu	ial Occup	ation			16b. K	ind of Busi	ness/Ind	ustry	
<u>.</u>	n 72 n "ns Wedic	plet	(Specify only highe Elementary/Secondary (0-12)	st grade completed	(1-4or 5+)	(Give	kind of w	ork done d use retired	during most ()	t of workin	g	,			,	
7	giene giene er tha	Completed	12	Conogo		5	Secre	tary			ative		Assoc		ons	
and	be file tal Hy d oth event	Be (	17. Father's Name (First, Middle,								(First, Middle, .ora Li					
<u> </u>	d Men narke	은	Robert Harriso		\$	10h Mailie	a Addros	c /Street			Route Numbe				Code)	
<u>a</u>	d2sh thand treun treun		John A. Taylor				-				ilver				20906	
<u>ත</u>	s 1 an f Heal item 2		20a. Method of Disposition			Place of Dispo	sition (Na	me of			ate		ocation - C			
Ê	Page: sent o int: If iry or		1 ☐ Burial 2 ☐ Cremation `4 ☐ Donatien 5 ☐ Other (S		n State   .	nesapea				12/	7/04	E	Belts	7 <b>i</b> 111	e, MD	
Баппрог	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked eny injury or other treumatic et <u>once</u> .		21. Signature of Funeral Service	Licensee /	//				ss of Facilit	-	comptio	n Co	wirio			
n —	89 E 29		23a. Part 1. Enter the disease, o	Hall	and						ematio				1.0	
		ļ,	shock, or heart failure. List	only one cause or	each line.						respiratorya	rrest, C	,		Interval Bets Onset and I	Weell
, 1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	Endstage		ic L	ung I	Diseas	se				-	20 ye	ars
	Examiner			Due to	o (or as a consec	quence or):										
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	o (or as a conse	quence of):										
1.	nd nd transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	) c												
1,00/8	cate be executed physician and the burial-transit	EX	19 Sulling III Gealthy Last	Due to	o (or as a consec	quence ot):										
789	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical		d												
ВОХ	leath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o	outcome of pregn		75						23d. Date	of delive	ry	
	death	Physician/M	in the past 12 months?		gnant at time of		Other (s	oregnancy pecify)					Monti	h	Day 1	rear .
J.	ires that the de signed by the a I be detached f	Phys	9 □ Unknown X						- in Book I		220 Did t	obacco	usa contrib	uto to th	e cause of d	leath?
	ires th signed	by	Part II. Other significant conditi	ons contributing to	death but not re	suiting in the u	naeriying	cause giv	en in Fait i.			Yes 2			ably 4 🗆	
Records,	w require been sig should b	Completed									24a. Was			are autor	sy findings	available
Ž	The law ate has page 2 s	ldm									autor	osy ormed?	pri de	or to con ath?	apletion of ca	ause of
_		မ လ	25. Was case referred to medica	1					26. Place	of Death	1 Yes		1 1 1	Yes	2L1 No	
<u> </u>	yaicie is cert direct	To B	examiner? 1 Tes 2 No	Hospital:	Inpatient 2	] ER/Outpatie	nt 3 🗆 🖸	OA Oth	er-		ne 5 Resi		6 Other	(Specify	)	
0	ng Ph fter th neral		27. Manner of Death 1X Natural 5 Pendi		te of Injury onth, Day Year)	28b. Time o		28c. Injur Wor	K?		8d. Describe	how inju	гу оссиггес	dt		
Division of	tendii leath. tor: A the fu	cati		gation not be			M		Yes 2 🗆		Of Location /	Stroot as	ad Number	or Pura	Pouto Num	har
$\leq$	or At after d Direct in by	Certification:	4 Homicide deter	nined 289. Pla	ce of Injury - At I Iding, etc. (Spec	nome, rarm, st ify)	reet, facto	ry, office		2	8f. Location ( City or To			or Hurai	HOULE INUITE	001,
_	To the Hospital or Attending Physicien: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director.		29a. Certifier 1 XCertifyi	ng Physician: To t	the best of my kn	owledge, deat	h occurre	d at the tin	ne, date an	d place, a	nd due to the	cause(s	) and man	ner as sta	ated.	
	n 24 h	edical	(Check only 2 Medical one)	Examiner: On the	basis of examin anner stated.	ation and/or in	vestigatio	n, in my o	pinion, dea	th occurre	d at the time,	date an	d place, an	d due to	the cause(s	)
	To the To the Comp	Σ	29b. Signature and title of certifie	1		4	2 2	c. Licens					ite signed (			
			Thorse	29/1	/lu	pl	2/		D121	121			Decen	ber	6, 20	04
	4		30. Name and address of person Dr. George	who complete ca	use of death (Ite	Ж 23a) (Туре, 929 Fer		Dris	TO TITL	nesto	n. MT	209	06			
	* St	ate	31. Date filed (Month, Day, Year		. Registrar's Sign	atum			VI e	icalu	עונג פיי	203				
	Regist		DEC 0.9.200	14 per	and some	D A	Loon	21								

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Physician 12-07-2004 4:58 PM Marjorie E. Trumbower /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Westminister Nursing and Convelescent Westminister
If Under 24 Hrs. 8. Date of Birth
Hours Min. 12-06-1919 Ctr If Under Carroll 1 Year 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) MA **Funeral** Months Days 1□ M 250F 018-12-0519 85 Director Usual Residence of Decedent the Merylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 1 ☐ Yes Q ☐ No Md Carro11 **Eldersburg Funeral Directo** 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3981 RobinHood Way 21784 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours efter 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2 ☐ Merried Specify White Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specily: þ 3. Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Clerk 12 Retail h end Mental Hygie 7 Is marked other t 17. Fether's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame) 8 2 Mary Elizabeth Colby John C. White Peges 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) other t 3981 RobinHood Way Eldersburg, Maryland 21784 Gwendolyn East Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ( to ) 1 ■ Burial 2 Cremation 3 Removal from State 6 Lake View 12/09/04 Sykesville, Md 4 ☐ Donation 5 ☐ Other (Specify) Injury 22. Name and Address of Facility Loring Byers Funeral Directors Inc 21. Signature of Funeral Service Licensee 8728 Liberty Road Randallstown, Maryland Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examine buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as e consequence of) requires that the death certificate be execu physician s the buriel Box 68760 Physician/Medical Due to (or as e consequence of): ettending ph d for use es t signed by the eld be deteched f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? certificate has been si irector, pege 2 should 24a. Was an autopsy performed? Completed tL Yas 2-2N 1 ☐ Yes 2 ☐ No director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Medicai Certification: To rs efter deam.

ral Director: After this c 1 ☐ Yes 2 KNo 1 Inpatient 2 ER/Outpetient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Menner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Netural 5 Pending investigation 1 Tes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital or To the Hospital
within 24 hours e
To the Funeral C 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted. 29a. Certifier 29d. Date signed (Month, Day, Yeer) 29b. Signature end title of certifier 29c. License number 30. Name/and address of person ause of deeth (Item 23e) (Type, Print)

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

DEC 0 9 2004

Dacks

32. Registrar's Signeture

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 100 14

			State	naryland / Department of Health and f Certificate of Death	Viental Hygiene Reg. No.	004 39013
	e de		Registrar  Decedent's Name (First, Middle, Last)		2. Date of Death Month Day	3. Time of Death
	Physicia /Medic	al	BOBT GELL VAUGHI	V	December	4 2004 3 35PM
	Examin		a. Facility Name (If not institution, give street and number)	1. 1 1 1 -	40.0	County of Death
	Funeral			Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
	Director		Vone 10M 2XF	Yrs. Months Days Hours Min.	December 4, 20	104 MD
	and w		Jsual Residence of Decedent  0a. State 10b. County	10c. City, Town or Location		10d. Inside City Limits
	Mary e-f sho	tor	MD Baltimore	Essex		1 ☐ Yes 2 No
	or 28	Director	0e. Street and Number	10f. Zip Code	10g. Citize	en of What Country?
	s 23a	erai	1306 Four Winds 12. Was Deceder	nt Ever in U.S 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	4. Race - American Indian,
9	after d	Funerai	1 Never Married 2 Married 1 Yes 2 If Yes, Give	s? If Yes, specify Cuban, Mexican, Puert No 1 □ Yes 2 No Specify:		Black, White, etc.
Maryland 21215-0036	be filed within 72 hours after death with the Maryland nial Hygiene. ad other than "natural", or Items 23a or 28e-f show event, Ita Medical Examinat must be multified at	d by	3 Widowed 4 Divorced Year or Dates	16a. Decedent's Usual Occupation		d of Business/Industry
7.	n nat	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4c)	(Give kind of work done during most of wor	rking 166. Kills	7 Of Business/moustry
212	filed withi Hygiene. other ther	Com	Elementary/Secondary (0-12) College (1-4c	-ntan't	<u> </u>	nfant
and	be d la	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nar	me (First, Middle, Maiden S	umame)
7	2 should be and Mental is markad of sumatic eve	2	James  19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Ru	ural Route Number, City or	Town, State, Zip Code)
	is 1 and 2 should of Health and Meritam 27 is marks other traumatic		S.BML. PATHOLOGY	GOSINICHARLES ST.	Towson 21.	204
ore	m		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from Sta	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Loc	ation - City or Town, State
Baltimore,	permit. Pag Department Importent: I any injury o		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee _	22 Name and Address of Facility	18/2005 180	TO. CET, M.
Ba	permit. Departn Importe any inju		1 July Claud	HENRY W. JENKING	monkier, m	? 7111
			23a. Par1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	sed the death. Do not enter the mode of dying, such as cardiac in line.	or respiratory arrest,	Approximate Interval Between Qnset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	EME PREMITURITY		FERL
	Examiner		Due to (or	as a consequence of):		
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	as a consequence of):		
	ecuter and I-transi	Examiner	that initiated events c.	as a consequence of):		
68760,	icate be executed physician and s the burial-transit	alE	d			
_	The law requires that the death certificate be executed tae has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Medical	IF FEMALE:			
Box	eath certifi attending i I for use as	Physician/M	23b. Was decedent pregnant	me of pregnancy  2 □ Fetal death 3 □ Ectopic pregnancy t at time of death 5 □ Other (specify)	2:	3d. Date of delivery  Month Day Year
0.	the de y the a	ysic	1 Yes 2 No 9 Unknown 9 Unknown		D	ecember 4, 2004
30	w requires that the de been signed by the s should be detached	by Pt	Part II. Other significant conditions contributing to deat	h but not resulting in the underlying cause given in Part I.		e contribute to the cause of death?
2 g	require een sig nould b	ted			1 Tes 2	
orall lphaRecord	has b	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
-ital	rsician: The law s certificate has b lirector, page 2 s		25. Was case referred to medical	26. Place of De	1 ☐ Yes 2 No ath (Check only one)	1 Yes 2 No
of Vi	Physician: this certific ral director,	To Be	examiner? 1  Yes 2 No Hospital: 1 X Inp.	Other	dome 5□Residence 6	
( )	ling PI		Talulai 3 1 bilding	njury 28b. Time of 28c. Injury at Work?  M 1 □ Yes 2 □ No	28d. Describe how injury	occurred
by (	Attending r death. ector: Afte by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of determined	Injury - At home, farm, street, factory, office	28f. Location (Street and	Number or Rural Route Number,
Sign	tal or rs after el Dire	Cert	4 Homicide determined building,	etc. (Specify)	City or Town, State)	
60	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one)  1 Certifying Physicien: To the basi and manner	est of my knowledge, death occurred at the time, date and place s of examination and/or investigation, in my opinion, death occu stated.	e, and due to the cause(s) a urred at the time, date and p	ind manner as stated. place, and due to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	29c. License number	29d. Date	signed (Month, Day, Year)
			Hoeocer Mends	occess DZ7475	DEC 9	non 1,2004
			30. Name and address of person who completed cause of	of death (Item 23a) (Type, Print)  M. D. 6701 N. Charles St.	Dagan 235	8 Bulto M.D
		ate	31. Date filed (Month, Day, Year) 32. By	istrar's Signature	1100111200	0, 20110.,11110.
	Regist	rar	DEC 0 9 2004	we to posser		

		1 - For Stata Registrar	ricase	-		and / De	epartment of Certificate	of Heal	Ith and M	lental Hyg	9	) l. o	0011
		Decedent's Name	(First, Middle, La	st)			- Inouto	0, 00,	1	2. Date of Deat		1 4 J	ime of Death
Physici			ouise W							Month	Day	Year	
/Medic Examir		4a. Facility Name (If r			mber)				ation of Death	Decembe	4c. County of		0:20 P <sup>M</sup>
		Anne Arun 5. Social Security Nur				rs. last birtho	Annar		Inder 24 Hrs.	0 D.1. (B)	Anne A		
Funeral Director		214-66-09	72	_M 2₹7F	7. Age (III y	48 Yr	Months D		ours Min.	B. Date of Birth (Month, Day, Feb 18,	Year) 1956	9. Birthplace (S Country) Maryla	and
and *		Usual Residence of D	lecedent 10b. County		10c.	City, Town o	or Location					10d Inc	ide City Limits
daryl r sho	៦	Tilinaia	Cools		1	estche							Yes 2X No
the 28e-	Director	Illinois  10e. Street and Numb	Cook		VV	escen	10f. Zip Co	nde		1	Og. Citizen of W		
3a or		2326 Kensi	ngton A	venue			10.1.2.	601	54	'	USA	nat Country :	
ms 2	Funeral	11. Marital Status		12. Was Dece	dent Ever in	U.S.	13. Was Deceden If Yes, specify			cify Yes or No-		- American Indi	an,
after or Ite	by	1 🗌 Never Married	2 Married	Armed For 1 ☐ Yes If Yes, Giv						Rican, etc.)		, White, etc.	
rel', c		3 Widowed 4	Divorced	Year or Da	ates:		1 Li Yes 2L	1 ☐ Yes 2 ☐XNo Specify:			Specify:	White	
72 h	Completed		5. Decedent's E			(0	ecedent's Usual C	done durino	most of worki	na	16b. Kind of Bus	siness/Industry	
within	E E	Elementary/Second	lary (0-12)	College (1	-4or 5+)		fe. DO NOT use i	,			D 1- 3	•	
is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mentel Hygiene. If Health and Mentel Hygiene. It marked other then "neturet", or Items 23a or 28a-f show inter Zis marked other then "neturet", or Items 23a or 28a-f show other treumatic event, the Medical Examination into the rollines at		17. Father's Name (Fi	irst Middle Last	<u> </u>		Adın	inistrat			(First, Middle, M	Banki		
d be antal	Be c	Albert V						10.1	_	Smith	alderi Surrame	7	
shoul nd Me mark mati	2	19a. Informant's Nam		Type, Print)		19h M	lailing Address (S	treet and N			City or Town S	tata Zin Codal	
uth ar 1th ar 27 is r treu		Dean B. W			4		26 Kensi						54
f Hearitem		20a. Method of Dispo	sition		20b	. Place of D	isposition (Name crematory or othe	of			Oc. Location - C		
Page lent o nt: If ry or		1 □ Burial 2 □ 1 □ Donation 5					Crematory or online		12/08	/04	Baltimor	e. Mary	zland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Brain in the Azis marked other than "neturel; or flems 23a or 28e-1 show any injury or other treumatic event, the Medical Examinating the rodified at ODGs.		21. Signature of Fune			1 17	EFTO (	22. Name and A	Address of I	Facility				Tarra
9 9 4 9		Thomas	Gregor	_			Crematic 299 Free	on Sod	ciety O k Road	I Maryla Baltimon	and Inc.	zland 21	228
- 11		23a. Part1. Enter the		plications that ca	aused the de	eath. Do not	enter the mode o	f dying, suc	ch as cardiac o	r respiratory arre	st,	Appro	ximate al Between
Physician		Immediate Cause (Fi			20111110.	401	Onic					Onset	and Death
/Medical		resulting in death)		Due to (	or as a cons	equence of)						100	nos
Examiner		Sequentially list cond	itions.	b									
sit ad	iner	Sequentially list cond if any, leading to imm cause. Enter Underly	ediate ring	Due to (	or as a cons	equence of)							
ecute and -trans	Examiner	that initiated events resulting in death) La		C	05.05.0000	equence of):							
ate be executed nysician and he burial-transit	cal E	<b>3</b>		Due to (t	or as a corrs	equance or).							
phys phys s the	edic			_ d									
certif nding use a	/Me	IF FEMALE: 23b. Was decedent p	roanant	23c. If yes, outo	come of pred	gnancy					23d. Date	of dollaron	
death atter d for u	ciar	in the past 12 m	onths?		irth 2 ⊟Fi ant at time o		3 ☐ Ectopic pregr 5 ☐ Other (specif				Mont		Year
the c by the achec	Physician/M	1 ☐ Yes 2 🕅 9 ☐ Unknown	40	9□ Unkno	wn								
The law requires that the death certificate tee has been signed by the attending phys bage 2 should be detached for use as the	by P	Part II. Other significa	ant conditions	ontributing to de	ath but not r	esulting in th	e underlying caus	a given in f	Part I.	23e. Did tob	acco use contrib	ute to the caus	e of death?
w require been sig should b										1 ☐ Ye	s 2 <b>25</b> No 3	Probably	4 ∐Unknown
e law re has beo je 2 sho	ompleted									24a. Was an		ere autopsy find	lings available
The I										autopsy perform 1 Yes 2	ed? de	or to completion ath? ∃Yes 2□ No	
ysicien: The is certificate director, pag	Be C	25. Was case referred examiner?	d to medical					26. 1	Place of Death	(Check only one			
di is	2	1 ☐ Yes 2 No		Hospital:	npatient 2	☐ ER/Outpa	itient 3 DOA	Other: 4 (	☐ Nursing Hom	ne 5 🗆 Resider	nce 6 Other	(Specify)	
ing After une	on:	27. Manner of Death 1 Natural	5 Pending		of Injury h, Day Year)	28b. Tim Inju	ry	Injury at Work?		8d. Describe how	v injury occurred	i	
tend death tor: / the f	icat	2 Accident 3 Suicide	investigation  6  Could not b		-/ I-l A4		М	1 🗌 Yes	-	0/ 1 /0:			
or A after Direc in by	ertification;	4  Homicide	determined	28e. Flace	of Injury - At ng, etc. (Spe	cify)	, street, factory, of	fice	2	8f. Location (Str. City or Town,	et and Number State)	or Rural Route	Number,
Hospitel or Attending 44 hours after death. Funerel Director: After tely filled in by the funer	O	29a. Certifier 1	Cartifying Ph	vsician: To the	hest of my k	nowledge d	eath occurred at t	he time da	te and place a	nd due to the co	ico(c) and man	or an atalad	
To the Hospitel or Attend within 24 hours after death To the Funerel Director: A completely filled in by the form	edicai	(Check only 2 one)	Medical Exar	niner: On the ba and mann	isis of exami	nation and/o	r investigation, in	my opinion	, death occurre	d at the time, da	te and place, an	d due to the car	use(s)
To the within 2 To the comple	Š	29b. Signature and th	le of certifier	1000			29c. Li	cense num	nber	29	d. Date signed (	Month, Day, Ye	ar)
X		17.7	xwiii	aju	,			0191	858	ì	12/7	12004	t .
		30. Name and ad res Stravt	s of person who E. Sel	COMPLETED CAUSE	e of death (It	ет 23a) (Ту 90 (	Besta	ate R	Rd. A	nnapoli	s, und.	214	01
Sta Registr		31. Date filed (Month,		32. Re	egistrar's Sig	nature	1						
1091011		UEG	0 9 2004	Parker 12	Carlo Maria	feel	1000K	21					

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Certificate of Death

Dorothy Ida Werking /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Sinai Hospital of Baltimore Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | Min. | March 17,1932 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 20F 72 Yrs. Director 395-30-0182 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan arment of Heath and Mental Hygiene. or items 23a or 28a-f show orlent: If item 27 is marked other than "naturel; or items 23a or 28a-f show injury or other traumatic event, the Marital Examinat must be routilled at Directo Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 16505 Virginia Avenue 21795 Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MERKING, DOROTHY 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Customer Service 17. Father's Name (First, Middle, Last) Albert Sellent Ida Erb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16505 Vir inia Avenue Williamsport, Maryland 21795 Albert E. Werking, Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 XCremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. `4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 12/09/04 21. Signature of Funeral Service Ligense
Thomas Gregor <sup>22. Name and Address of Facility</sup> Cremation Society Of Maryland Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Mitral stemosis /Medical Due to (or as a consequence of): Examiner Rheumatic fever Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): physician P.O. Box 68760 certificate be Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by I Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. by Chronic atrial fibrillation Completed artery 24a. Was an has 1 Yes Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Unpatient 2 ☐ ER/Outpatient 2 1 ☐ Yes 2 ☑ No 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: After 5 Pending investigation within 24 hours after death. To the Funerel Director: A М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number exer W Cho MiD. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peter W. Cho Baltimore Sinai Hospital of M.D.

. Decedent's Name (First, Middle, Last)

**Physician** 

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2. Date of Death Month Day 0905 AM DECEMBER 03 2004 4c. County of Death N/A Birthplace (State or Foreign Country) Wisconsin 10d. Inside City Limits 1 ☐ Yes 2√2 No 10g. Citizen of What Country? USA Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Retail Store 18. Mother's Name (First, Middle, Maiden Sumame) 20c. Location - City or Town, State Baltimore, Maryland Approximate Interval Between Onset and Death years years 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 12 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? performed? 2 No 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) DECEMBER 03, 2004 2435 W. Belvedere Ave,

Baltimme

MD 21215

State

Registrar

31. Date filed (Month, Day, Year)

DEC 0 9 2004

32 Registrar's Signature

	•	State of Maryland / Department	artment of Health and I rtificate of Death		ene 2001	39016	
Physicia		Decedent's Name (First, Middle, Last)	VALKER, SR	2. Date of Death Month 12	Day 2004	3. Time of Death 03:20 M	
/Medic Examin		4a. Fecility Name (If not institution, give street and number) Sinai Hospital	4b. City, Town, or Location of Death Baltimore		4c. County of Death NA		
Funeral Director		5. Social Security Number  3.13-62-9394  6. Sex 1 M 2 F  7. Age (In yrs. last birthday)  Yrs.  Usual Residence of Decedent	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Y	9. Bin Co	thplace (State or Foreign ountry) MD	
Maryland -f show	tor	10a. State				10d. Inside City Limits  XXYes 2 ☐ No	
with the M s or 28a-f be notifie	Direc	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Co	puntry?	
If it is not safer death with the Maryland Hygiene. Hygiene, then "naturel", or items 23s or 28s-f show ont, the Medical Examinat must be notified at	by Funeral Director	2540 Loyola Northway  11. Marital Status  1 Never Married  Married 3 Widowed 4 Divorced  25. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 1 Never Married 2 Never N	Was Decedent of Hispanic Origin? (Siff Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	nican Indian,	
ithin 72 hours he. han "naturel", Medical Ene	Completed b	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occupation kind of work done during most of wor DO NOT use retired)	rking	b. Kind of Business	/Industry	
	Be	17. Father's Name (First, Middle, Last)		ne (First, Middle, Ma	arine Te niden Surname)	rminal	
12 should be and Mental ris marked c	10		ng Address (Street and Number or Ru		City or Town, State, 2	Zip Code)	
permit. Pages 1 and 2 Department of Health at Importent: If item 27 is any Injury or other tratence.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	matory or other place)	Date 20	1to, Md oc. Location - City or		
permit. P Departme Importen any Injur.		21. Signature of Funeral-Barvice Licensee	n Cemetery 12/8 2. Name and Address of Facility March F.H. West	3/04   Ba Ba 4300 Wab	ltimore,	Md. 21215	
Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):				Approximate Interval Between Onset and Death	
ate be executed hysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):					
To the Hospitel or Attending Physicien: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medic		□Ectopic pregnancy □ Other (specify)		23d. Date of del Month	ivery Day Year	
quires that n signed by	þ	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did toba		the cause of death?	
The law recate has bee	Completed			24a. Was an autopsy performe	prior to o	atopsy findings available completion of cause of	
ysicien: s certific	To Be	25. Was case referred to medical exeminer?  1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatie	Othor	ath <i>(Check only one)</i> Iome 5 ☐ Residen	ce 6 □Other (Spec	cify)	
nding Ph ath. r: After th		27. Manner of Death  1 Matural 5 Pending (Month, Day Year) 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	of 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how	injury occurred		
To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	et and Number or Ru State)	ural Route Number,	
he Hospi in 24 hour the Funer pletely fill	edical	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	evestigation, in my opinion, death occu	rred at the time, date	and place, and due	to the cause(s)	
to t With To t	Σ	29b. Signature and title of certifier $\mathcal{M}$ . $\mathcal{D}$ .	29c. License number D0062100		I. Date signed (Monti	67, 2004	
4		30. Name and address of person who completed cause of death (Item 23a) (Type, 401 NORTH BROADWAY	BALTIMORE, N	IARY LA.	ND ZI	231	
Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Signature	Sparks!				

Sylvester Walden 04-07745 Unpend item#23a,27, perME, G838,12/18 /04 Th. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene crn Certificate of Death Reg. No. U Ls 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** December 02, 2004 Sylvester 9:30 Ам Walden /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1319 Southview Drive, Apartment 203 Oxon Hill Prince George's 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 03 26 **Funeral**  Birthplace (State or Foreign Country) 1☐M 2□ F Director 223-78-0093 53 VÁ Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. Count 28e-f show 10d. Inside City Limits treumatic event, the Madical Exeminer must be notified at Director 1 ☐ Yes 2 ▼No MDPrince Georges Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Items 23e 1319 Southview Drive Apt 203 20745 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, s 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 271s marked other than "natural", or Itel Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 ☐ Widowed 4 ₺ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Unemployed lyr Unemployed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Walden Bertha Whitehead 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15065 Almansor Pl., Haymarket, Va 20169 Jonathan Walden-Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date permit. Pages 1
Department of H
Importent: If ite
any injury or ot 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State \* 4 □ Donation 5 □ Other (Specify) Metro Crematory Inc. 12/8/04 Baltimore, Md 21. Sgnatur of Funeral Service Licensee 22. Name and Address of Facility 4 mosino 4300 Wabash Ave, Baltimore, Md Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death **Physician** disease or condition resulting in death) a Complications of Chronic Alcohol Abuse /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Examiner Due to (or as a consequence of): the attending physician and hed for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. detached 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of deeth?

1 ✓ Yes 2 □ No 24a. Was an performed? certificate 1 Yes 2 🗆 No Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death Check onl one) engaminer? 1 Yes 2 No Other: 4 Nursing Home 5 Residence Scher (Specify) at scene ٢ 1 Inpatient 2 ER/Outpatient 3 DOA this: 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by after 4 Homicide 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 the

State Registrar

31. Date filed (Month, Day, Year) DEC 0 9 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Pamela

111 Penn Street, Baltimore, Maryland 21201 E. Southall. MD 32. Registrar's Signature

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

December 03, 2004

0

			For	Sta	ite of Ma		partment of		Mental Hygi		
			1 - State Registrar		_		ertificate of	Death	Re	g. No. 2 U U 4	39018
	Physici	an	1. Decedent's Name (First, Min	ddle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Annetter		dard				November		5:10 A M
	Examir	er	4a. Facility Name (If not institu	_				or Location of Death	1	4c. County of Deat	th
			1220 Blair Mil 5. Social Security Number	LL Road 6. Sex	#1105	(In yrs. last birtho		Spring If Under 24 Hrs.	O Const of Dight	Montgom	
	Funeral Director		577-52-2007	1 M 2		TO YES	Months Days		(Month, Day,		thplace (State or Foreign buntry)
			Usual Residence of Decedent	·	Δ.	, 0			Nov. 14	, 1934 u	<u>nobtainable</u>
	yland		10a. State 10b. Cou	nty		10c. City, Town o	Location				10d. Inside City Limits
	Mar 6-1 sl	ctor	MD N	lont gome	ry	Silv	er Spring				1 TYYes 2 □ No
	or 28	olre	10e. Street and Number				10f. Zip Code		10	g. Citizen of What Co	ountry?
	23e	by Funeral Director	1220 Blair N	iill Roa	d, Apt	. 1105	20	910		United Sta	ates
	tems	nue	11. Marital Status	An	is Decedent E ned Forces?		<ol> <li>Was Decedent of If Yes, specify Cul</li> </ol>	Hispanic Origin? (S can, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White	
36	s afte	y Fi	1 ☐ Never Married 2 ☐ M 3 ☐ Widowed 4 🔯 Divorce	arried 1 [	]Yes 2□ N 'es, GiveX	lo	1 ☐ Yes 2 █XNo	Specity:			African-
5-0036	72 hours after death with the Maryland natural', or Items 23e or 28e-f show disal Examinat must be notified at	pa pa		ent's Education	ar or Dates:	162 0	ecedent's Usual Occu	nation	1 4		American
15	in 72 n "na neziio	Completed	(Specify only hig	hest grade comp		(0	ive kind of work done  B. DO NOT use retire	during most of wor	king	D. Kind of Business/	industry
2121	I with liene.	Ho	Elementary/Secondary (0-12	2) Co	llege (1-4or 5 1	+)	computer	•	r	Insurance	Company
b	filed I Hyg othe	BeC	17. Father's Name (First, Midd	le, Last)					ne (First, Middle, Ma		
<u>a</u>	uld be denta rked tic ev	To B	unobtainab	1e				Lucille	Roseboro	ugh Johnso	on
Maryland	smd N	-	19a. Informant's Name/Relation	nship (Type, Pri	nt)	19b. M	ailing Address (Stree	<u> </u>		City or Town, State, 2	
	and 2 salth n 27 I		Linda S. John	son/sis	ter-in		00 Dogwoo	d Lane, F	orestvill	e, MD 207	747
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	n 3 🗆 Bemova	I from State	20b. Place of Di cemetery,	sposition (Name of crematory or other pla	ісе)		Oc. Location - City or	
Ë	Pag ment tant: jury c		* 4 □Donation → □Other	(Specify)		Chesapea	ke Cremat	0-5		eltsville,	, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23e or 28e-f show any injury or other treumetic event, the Medical Examiner must be notified at ance.		21. Sign ture of Funeral Servi	ce Lice see	La 11	and	22. Name and Addr Rapp Fun	ess of Facility eral and	Cremation	Services	
	403 8 Q		MURU C	11/1	all	WICH	933 Gist	Avenue,	Silver Sp	ring, MD	20910
			234. Par 1. Enter the disease shock, or heart failure. L	ist only one caus	se on each lin	e.	enter the mode of dy	ing, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	un	Uiple	infur	185			Ondot and Doam
	Examiner		,		Oue to (or as a	cons-fuence of):	V				
		ē	Sequentially list conditions, if any, leading to immediate	b	Due to (or as a	consequence of):					
V.T	uted	E in	Sequentially list conditions, if any, leading to immediate cause. Enter Underving Cause (Disease or injury that initiated events	1							
oʻ	exec an an rial-tr	Examiner	resulting in death) Last	C	Due to (or as a	consequence of):					
68760,	icate be executed physician and s the burial-transit	edical		d.							
			IF FEMALE:								
Вох	eath certific attending pl	an/l	23b. Was decedent pregnant		es, outcome o		3 Ectopic pregnanc	·v		23d. Date of deli	•
	law requires that the death certif as been signed by the attending 2 should be detached for use a	Physician/M	in the past 12 months?  1  Yes 2 No 9 Unknown	4	Pregnant at		5 Other (specify)	<u></u>		Month	Day Year
P.0	d by fetach		Part II. Other significant cond	itione contributir	a to death h	t not coculting in th	a undarkina sausa si	una in Dant I	22a Did taha		the agree of death 0
JS,	ires thai signed t	l by	raitii. Other significant cond	itions contributi	ig to death bu	a not resulting in th	e underlying cause gi	ven in Part I.		cco use contribute to	bably 4 Unknown
0.00	w requir been si should	etec									
Records,	9 4 9	Completed							24a. Was an autopsy performe	prior to c	topsy findings available completion of cause of
a		e Co	05.11						1 <b>2</b> Yes 2		2 No
Vital		m	25. Was case referred to medi examiner? 1 √√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√	Hospital	1 🗌 Inpatier	nt 2 🗆 ER/Outpa	0000	nor.	th (Check only one)	2400000	
of		n: To	27. Manner of Death	28a.	Date of Injur (Month, Day		of 28c. Inju	4 🗀 Indising H	ome 5 Residence 28d. Describe how	injury occurred	
ion	Attending It death. Sector: After by the fune	atlo	1 ☐ Natural 5 ☐ Pen 2 ☐ Accident inve	at the same of	Month, Day		y A Wo	rk? Yes 2 XNo	Subject ju	empled from	n building
Division	or Attenation	iffica	3 Suicide 6 ☐ Cou 4 ☐ Homicide dete	d not be		ry - At home, farm.	street, factory, office		28f. Location (Street	et and Number or - u	M'r M'URU.
Ö	tal or	Certification:			G.	ground	beneath	Capartment	Silver Spi	149 MB	ar puaka.
	t hour tuner	cal	29a. Certifier 1 Certif	ying Physician: al Examiner: Or	To the best of	f my knowledge, d	eath occurred at the t	me, date and place,	and due to the caus	se(s) and manner as and place, and due	stated.
	To the Hospital or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Medical	Unite)	an	d manner stat	ed.					
V	To To con	~	29b. Signature and title of certi	ner n	10.		29c. Licen	se number	29d	. Date signed (Month	i, Uay, Year)
•		}	calrine	was	HE			.M.E.	No	vember 19	, 2004
	6		ZABILL	AH	a cause of de	ath (Item 23a) (Ty	,	n Street,	Baltimor	e, Maryla	nd 21201
	Sta Registr		31. Date filed (Month, Day, Yea		32. Registra	r's Signature	Spark			•	
							1000	47			

		For State Registrar	State of Maryland	d / Depa <i>Cel</i>	artment of H rtificate of L	ealth and N Death	Mental Hygie		39019
		Decedent's Name (First, Middle, Last)					2. Date of Death	_	3. Time of Death
Physic /Medi		Teresa	S.		Williams		De Cembe	L 2.200	715:25PM
Exami		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or	Location of Death		4c. County of De	
		NORTH HRUN	DEL HOSPI	TAL	G /ETV A	DURNIE If Under 24 Hrs.	10.0		UNTY
Funeral Director		5. Social Security Number 6. Sex 1218-80-3049	M 2XDF	is <i>t birtnd</i> a <i>y)</i> Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, You 9-19-6	997)	Birthplace (State or Foreign Country)  Md.
		Usual Residence of Decedent	<u> </u>					,,,,	1101
nylane how		10a. State 10b. County	10c. City,	, Town or Lo	ocation				10d. Inside City Limits
8a-f	octo	Md. Anne Arur	ndel	Glei	n Burnie				11√ Yes 2 No
with the a or 2	Funeral Director	7846 Willing Ct.			10f. Zip Code 2106	51	10g	. Citizen of What USA	Country?
hs 23	era		12. Was Decedent Ever in U.S	5. 13.	Was Decedent of Hi	spanic Origin? (Sp	pecify Yes or No-		merican Indian,
after of the military		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give	i	If Yes, specify Cuba 1 ☐ Yes 2 🕱 No	n, Mexican, Puerti Specify:	Hican, etc.)	Black, W Specify: E	·
nours Leval	d by	3 ☐ Widowed 4 🌠 Divorced	Year or Dates:						
n 72 h	Completed	15. Decedent's Edu (Specify only highest grade	completed)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	luring most of won	king 16	b. Kind of Busine:	ss/Industry
iene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Shi	oping & Re	ecievina	אידו	IT Logist	America ics <sub>North</sub>
id be filed ental Hyg ked other ic event,	BeC	17. Father's Name (First, Middle, Last)			ppring u in	18. Mother's Nan	ne (First, Middle, Ma.	iden Sumame)	
Menta Menta arked	ToE	James	Dav			Bark			iams
DESIGNATION CE, INIGITY CALL IN-COUNTY  Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: filem 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at any injury or other traumatic event.	W \$	19a. Informant's Name/Relationship (Ty. Barbara Davis	pe, Print) Mother		•		ral Route Number, C , Baltimo	*	o, Zip Code) 21218
T and 1 and Health		20a. Method of Disposition	20b. Pla	ace of Dispo	osition (Name of			c. Location - City	
ages ant of ht: f it	1	1 ☑ Burial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		matory or other place  1 Mem. Gai		-9-04	Dundalk	Md.
mit. Pages mit. Pages partment of sortant: I it		21. Signature of Funeral Service License			2. Name and Addres		and the second second	nore, Md.	
any impo		south R.	Vatter		March F.H			North A	lve.
		23a 11. Enter the disease, or complished, or heart failure. List only or	ications that caused the death. ne cause on each line.	. Do not en	ter the mode of dying	g, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death
Physician	_	Im regiate Cause (Final diserse or condition	Prima	ey_	Vulmona	my Hy	Perteurio	-	Offset and Death
/Medical Examiner		resulting in death)	Due to (or as a consequ	en e of):		0			
	e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Dua to (or as a nonsequ	ianga of):					
uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events							
O, s exec en an irial-tr	Exa	resulting in death) Last	Due to (or as a consequ	ence of):			· · · · · · · · · · · · · · · · · · ·		
HECONGS, P.O. BOX 08/00,  The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the buriat-transit.	dlcal		d						
X OX	0	IF FEMALE:	3c. If yes, outcome of pregnan	nev				204 D-1	4-10-1-10-10-10-10-10-10-10-10-10-10-10-1
COIGS, P.O. BOX of wrequires that the death certific been signed by the attending!	Physician/M	in the past 12 months?	1 Live birth 2 Fetal 4 Pregnant at time of de	death 3[	Ectopic pregnancy Other (specify)			23d. Date of o Month	Day Year
the d	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown						
S that	by Pi	Part II. Other significent conditions con		ilting in the u	inderlying cause give	en in Part I.	23e. Did tobac	cco use contribute	to the cause of death?
ords aquire en sig		Hypertur	I Diahetts				1 Tes	2□No 3 <b>/</b> 2	Probably 4 Dunknown
HECOTOS, he law requires t e has been signe tge 2 should be o	Completed	Type	I Diahelis				24a. Was an autopsy	prior t	autopsy findings available o completion of cause of
	Con	Q.					performe	d? death No 1 □ Y	
VITAI lician: T certificat rector, pa	Be	25. Was case referred to medical examiner?	fospital:		Othe		th (Check only one)		
On OT VITA ding Physician: h. After this certific funeral director,	To	1 Yes 2 No	28a. Date of Injury	28b. Time o		4 ☐ Nursing H	ome 5 Residence		oecify)
nding nding tth: :: Afte	attor	1 ■ Natural 5 ■ Pending 2 ■ Accident investigation	(Month, Day Year)	Injury		(? Yes 2 □ No			
DIVISION  or Attending after death. Director: Afte	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, st	reet, factory, office		28f. Location (Stree City or Town, S	at and Number or State)	Rural Route Number.
ital or ris aft						<u>                                     </u>			
UNISION OT VITA To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the tuneral director,	edicai	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my knowner: On the basis of examinati and manner stated.	wledge, dear ion and/or in	th occurred at the time to the time of tim	ne, date and place pinion, death occu	, and due to the caus rred at the time, date	se(s) and manner a and place, and d	as stated. lue to the cause(s)
To the within To the comple	Med	29b. Signature and title of certifier	direction states.		29c. License	number		. Date signed (Mo	nith, Day, Year)
r sr o		1 Asall	MD		1	504	70 1	2/03	104
h		30. Name and address of person who co	empleted cause of death (Item	23a) (Type			MD 21	122	
× S	7	31. Date filed (Month, Day, Year)	32. Registrar's Signat		4				

DOS

		•	1 - State Unpend Item 2	State of Marylar 3a&27 per me	nd / Depa G838 Cei	artment of h	lealth and Beath	d Mental Hy	giene Reg. No.	004	39020
	Physicia		Decedent's Name (First, Middle, Last Johnnie	Antho	ony.	Willia	ams	2. Date of De. Month Decemb	Day	Year 2004	3. Time of Death
P	/Medic Examin		4a. Facility Name (If not institution, give Harbor Hospital	street and number)		4b. City, Town, o				County of Death	
	Funeral Director		Social Security Number 6. Se	x 7. Age (In yrs. XM 2□ F 47	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 h	drs. 8. Date of Birlin. (Month, Da	y, Year)		place (State or Foreign ntry)
	Aaryland f show	or	Usual Residence of Decedent  10a. State 10b. County  Md Anne Art		ty, Town or Lo	en Burnie					10d. Inside City Limits  My Yes 2 No
	or 28a-	Director	10e. Street and Number 99 Cherry Lane			10f. Zip Code 210	60		10g. Citiz	en of What Cou	ntry?
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. It fleat 121 is marked other than "natural; or items 23a or 28a-f show other traumatic avent, the Medical Examinating that it is a finited at	Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in L Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			lispanic Origin? an, Mexican, Pu	(Specify Yes or No verto Rican, etc.)		USA  4. Race - Ameri Black, White,  Specify: Bla	etc.
Maryland 21215-0036	within 72 hou ene. than "naturai he Medical E	Completed by	15. Decedent's Edi (Specify only highest grace Elementary/Secondary (0-12) 12th grade	ecation	(Give	dent's Usual Occup kind of work done DO NOT use retire Laborer	oation during most of d)	working		od of Business/In	
land 2	ould be filed within Mental Hygiene. arked other than " atic avent, I've Me.	To Be Co	17. Father's Name (First, Middle, Last) Unkn				18. Mother's Nell	Name <i>(First, Middle,</i> ie			
Mary	nd 2 should be lith and Mental 27 is marked of r traumatic av		19a. Informant's Name/Relationship (T) Elaine Brown	<sub>(pe, Print)</sub> Cousin				Rural Route Number, Baltimo			213
altimore,	iges 1 ar nt of Hea : If itam : or othan		20a. Method of Disposition 1√2 Burial 2 ☐ Cremation 3 ☐ I	Removal from State	Place of Dispo	sition (Name of matory or other pla	сө)	Date	20c. Loc	cation - City or To	
Baltin	permit. Pages 1 and 2 Department of Health a Important: if Itam 27 is any injury or othar tra once.		. 4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funeral Service Ligens		22	.11 Cem. 2. Name and Addre	ess of Facility		imor	e, Md.	1 Co,Md. 21202
	Physician /Medical Examiner		23a. yart. Enter the disease, or comp h. k, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that cause. The dean ne cause on each line.  a. AIDS  Due to (or as a conser	th. Do not ent	March F.F. er the mode of dyin				rth Ave	Approximate Interval Between Onset and Death
L	cate be executed physician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect.  Due to (or as a consect.							
68760,	fficate be g physicia as the bu	edical	(	d							
.O. Box	that the death certifics ed by the attanding ph detached for use as t	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3 □	Ectopic pregnanc Other (specify)	у		23	3d. Date of delive Month	ery Day Year
<u>α</u>	w requires that the been signed by th should be detache	leted by Ph	Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	nderlying cause giv	ven in Part I.				he cause of death?
Il Records,	The law ate has b page 2 sl	Complet						24a. Was autop perio 1 🗆 Yes		24b. Were auto prior to co death? 1 \(\sum \) Yes	psy findings available mpletion of cause of
f Vital	ysici s cer direc	o Be	25. Was case referred to medical examiner? 1 X Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 ☐	] ER/Outpatier	nt 3[XDOA Ott	200	Death <i>(Check only o</i>		□Other (Special	y)
Division of	De Ter	Certification; T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo	ry at	28d. Describe t			
É	Dir		4 Homicide determined	28e. Place of Injury - At I building, etc. (Speci	ify) 			City or Tov	vn, State)		al Route Number,
	he Hospital in 24 hours on he Funaral pletely filled	edical		rsician: To the best of my kn iner: On the basis of examin and manner stated.							
į.	To the To the Complet	Z	29b. Signature and title of certifier			29c. Licens OCME			<sup>29d. Date</sup> Decer	nber 5,	2004
			30. Name and address of person who c		m 23a) (Type,		Street	, Baltimo	re, l	MD 21201	_
	Sta Registr		31. Date filed (Month, Day, Year)	32. Pagistrar's Sign	ature	harte)					

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Henry M. Wiesenfeld 2004 December 12:10 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Gilchrist Towson Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
June 21, 1 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 X M 2 □ F 214-22-6132 97 Yrs. Director 1907 Maryland Usual Residence of Decedent 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at MD Baltimore Towson 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6601 N. Charles Street 21204 USA Itema 23a Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 Å Yes 2 □ No If Yes, Give Year or Dates: \*43-45 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. e filed within 72 hours after al Hygiene. I other than "natural", or Iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ð Specify: white 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done di life. DO NOT use retired) during most of working College (1-4or 5+) Elementary/Secondary (0-12) self employed sporting goods store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ss 1 and 2 should be fit of Health and Mental H I item 27 Ia marked otl Joseph Wiesenfeld Hattie Mann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Herstein/grt nephew 2215 Araen Road Baltimore, MD 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 ment of F tant: If itr 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. \* 4 X Donation 5 Dother (Specify) 21. Signature of Funeral S vice Licensee Runs 1 S Wadle, 22. Name and Address of Facility
State Anatomy Board
Baltimore, MD 21201 655 W. Baltimore Street mari 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or con the n Physician schemic cardionyopathi joans resulting in death) /Medical Due to (or as a consequence of): Examiner early ny pertensin Sequentially list conditions, if any, leading to limited into cause. Enter Underlying Cause (Disease or injury that initiated events Directo (or es a consequence of) Examine use as the burial-transit the attending physician and ned for use as the burial-tran resulting in death) Last Due to (or as a consequence of) 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23h. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No o. 9□ Unknown 9 Unknown à ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 INo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: certificate 2 No 2∏ No 1 ☐ Yes 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28c. injury at Work? 27. Manner of Sath 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation death **Director**: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after within 24 hours a 29a, Certifie Tacertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and itle of certifier 29c. License number 29d. Date signed (Month, Day, Year) NECEMBER 2 2004 and address of person who completed cause of death (Item 23a) (Type, Print) LES, MO 21204 6601 N. Charles Street Baltimore, MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 0 9 2004 Registrar

Wiesenfeld, Henry

			For State Registrar	State of M	aryland				lealth a Death		Re	g. No.	004		2
	Physici		1. Decedent's Name (First, Middle, La. Ellis M. Woodwa								2. Date of Death Month November	Day	Year 2004	3. Time of Death	M
)	/Medic Examir		4a. Facility Name (If not institution, given 233 Blenheim Ro					Town, or	Location o	f Death		4c. Cou	inty of Death	1	
	Funeral Director		5. Social Security Number 6. S 434–44–1002		ge (In yrs. Ia 84	st birthday) Yrs.		r 1 Year	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, Oct 10,	1920	9. Birth Cou Lot	plece (State or Foreig intry) 11sana	gn
	ith the Maryland or 28a-f ehow	ctor	Usual Residence of Decedent  10a. State 10b. County  MD		10c. City,	Town or Lo	altim							10d. Inside City Limit	
	th with the 23a or 2	al Dire	10e. Street and Number 233 Blenheim Roa	d			10f. Zi	p Code	21212		10	g. Citizen	of What Cou	intry?	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "natural", or Itams 23a or 28a-f show stay iglury or other treumatic event, the Medical Examinar most be notified at ance.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces' 1 X Yes 2 If Yes, Give Year or Dates:	No		Was Dece If Yes, spe 1 Yes		ispanic Origin, Mexican Specify:	gin? (Spe , Puerto F	cify Yes or No- Rican, etc.)		Race - Amer Black, White ecify:		
21215-0036	vithin 72 ho ne. hen "natur e Medical	Completed	15. Decedent's E. (Specify only highest grade) Elementary/Secondary (0-12) 12		5+)	16a. Dece (Give life.	kind of w DO NOT	ork done d ise retired	durina most		19	6b. Kind o	of Business/I	ŕ	
land 2	2 should be filed within 72 hours aft and Mental Hygiene.  Is marked other then instural, or feurnatic event, the Medical Exami	To Be Co	17. Father's Name (First, Middle, Last, Joseph Mellicha	)	rd			.ock	18. Mothe		(First, Middle, M	aiden Sun	finan mame)	clai	
, Maryland	and 2 shou ealth and N n 27 is mai		19a. Informant's Name/Relationship ( Patricia T. Wood		se						Route Number,		wn, State, Z 21212	ip Code)	
Baltimore,	Pages 1 ament of He ent: If Item ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ `4 ☒ Donation 5 ☒ Other (Specif	(Y)	COL	ace of Dispo metery, crea	matory or	other plac					on - City or 1		
Balt	permit. Departrimonte importe eny inju		21. Signature of Europal Service Licer Ronald		ector	Ba	altım	ore,	MD 2	21201	655 W.		imore		
	Physician /Medical Examiner		23a. Fart1. Enter the disease, 6r com shock, or heart failure. List only Immediete Cause (Final disease or condition resulting in death)	plications that cause one cause on each	v A		ter the mo	de of dyin	g, such as	cardiac or	respiratory arre	st,		Approximate Interval Between Onset and Death	
,160,	be executed sicien and burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as											
P.O. Box 687	ires thet the death certificate be executed signed by the attending physicien and deetached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal	death 3	⊒Ectopic p ⊒ Other (s						Date of delive	r <b>ery</b> Day Year	
	w requires thet the been signed by the should be detache	ed by PI	Part II. Dither significent conditions of	contributing to death	out not resul	lting in the u	inderlying	cause give	en in Part i.			2 N		the cause of death?	m
of Vital Records,	The law ate has b page 2 st	Completed by					-				24a. Was an autopsy perform 1 Yes 2	ed?	b. Were aut prior to c death? 1  Yes	opsy findings availab ompletion of cause of 2 No	le
Vita	Physicien: this certific ral director,	Be	25. Was case reterred to medical examiner?	Hospital:				Oth			(Check only one				
ō	Phys r this ral du	. To	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 🔲 Inpat		R/Outpatier 28b. Time o					ne 5 Resider 8d. Describe hov			ify)	
Division	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Medical Certification:	1 Autural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be 4 Homicide determined	e 28e. Place of In		Injury me, farm, sti	М		k? Yes 2⊡t		8f. Location (Stre City or Town,	et and Nu State)	umber or Ru	al Route Number,	
	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the	dical	29a. Certifier 1 Certifying Pl (Check only 2 Medical Exer	nysicien: To the bes miner: On the basis and manner s	of examination	vledge, deat on and/or in	h occurred	at the tin	ne, date and pinion, deat	d place, a th occurre	nd due to the car d at the time, da	use(s) and te and plac	manner as ce, and due	stated. to the cause(s)	
	To the within To the comp	Me	29b. Signature and title of certifier		us		1	c. Licens		192			gned (Month		
			30. Name and address of person who トルトセハ M.	Gorda	1 my	23a) (Type,	Print) 565	- N	. Cl	noul	45 54	Ra	ihm	2004 2004 MD 2	42
	St	ate	31. Date filed (Month, Day, Year)	32. Regist	rar's Signatu	Lagar	60								

ח			For State Registrar	State of M	Maryland / Depa <i>Ce</i> a	artment of He rtificate of D	ealth and M eath	lental Hygid	2004	39023
	Physici /Medic		Decedent's Name (First, Middle, I  Lewis	ast)	Ye	elity, Jr.		2. Date of Death Month December	Day Year 2004	3. Time of Death  2:25 P M
	Examin		4a. Facility Name (If not institution, g 500 Lyndhurst S		er)	4b. City, Town, or L Baltir			4c. County of Death	
	Funeral Director		243-38-5382	Sex 7 112 M 2□F	Age (In yrs. last birthday) 76 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Oay, ) 5–8–28	(ear) 9. Birth	place (State or Foreign intry) N.C:
	Aaryland I show	or	Usuel Residence of Decedent  10a. State 10b. County  Md.	NA	10c. City, Town or Lo	ocation imore				10d. Inside City Limits  Y☐ Yes 2 ☐ No
	with the N 3e or 28a-	I Direct	10e. Street and Number 500 Lynhurst S	treet		10f. Zip Code 21229		100	g. Citizen of What Cou USA	intry?
396	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Pygiene. Importent: If item 27 is marked other then "natural", or items 23e or 28e-f show any injury or other traumatic event, I'm Midfell Entitli et must be indiffied at ODGe.	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Wildowed 4 Divorced	12. Was Decede Armed Force	□No	Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
Maryland 21215-0036	i within 72 hou iene. r then "nature ine Madical E	ompleted	15. Decedent's (Specify only highest to Elementary/Secondary (0-12) 12th grade	Education grade completed) College (1-4d	(Give life.	dent's Usuat Occupati kind of work done du DO NOT use retired) Handler	on ring most of worki	ing	U.S. Post Office	,
land?	uld be filed Mental Hyg rked other tlc event,	To Be C	17. Father's Name (First, Middle, La	st)	Yelity		8. Mother's Name Virgini	(First, Middle, Ma		
	and 2 shores a strain and N n 27 is mare trauma		19a. Informant's Name/Relationship Jacqueline Yeli		Daughter	3500 Curr	ry Comb P	Point, Su	City or Town, State, Ziffolk, Va.	23435-324
Baltimore,	Pages 1 ment of He lent: If iter		20a. Method of Disposition  1 XBurial 2 ☐ Cremation 3  3 4 ☐ Donation 5 ☐ Other (Spe	city)	Md. Nat.	osition (Name of matory or other place)  Mem. Pk.	12-10	)-04	Laurel, Mo	l <b>.</b>
Balt	permit, Depart Import any inj		21. Signatur Funeral Service Lie	e_		2. Name and Address March F.H.	East	1101 E.	timore, Md North Ave	
	Physician		23a. Part1. Enter the disease, or co shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	<sub>a</sub> Hyperte	nsive Arteri					Approximate Interval Between Onset and Death
	/Medical Examiner	er	Sequentially list conditions, Tary, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	as a consequence of):					
8760,	cate be executed physician and the burial-transit	dical Examiner	cause. Enter Underkying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or	as a consequence of):					
Box 6	death certifi e attending id for use as	Physician/Medic	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown		2 ☐ Fetal death 3 ☐ t at time of death 5 ☐	Ectopic pregnancy Other (specify)			23d. Date of delive	rery Day Year
rds, P.O	w requires that the d been signed by the should be detached	by	Part II. Other significant conditions	s contributing to deat	h but not resulting in the u	inderlying cause given	in Part I.		cco use contribute to	\$7
al Records,	The law ate has b page 2 sl	Completed						24a. Was an autopsy performe	24b. Were autroprior to condeath?  No 1 Yes	opsy findings available ompletion of cause of
sion of Vital	Attending Physician: Thir death. ector: After this certificate by the funeral director, pag	atlon: To Be	25. Was case referred to medical examiner?  1 X Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigations	ion		nt 3 DOA Other:	4 Nursing Hor	n <i>(Check only one)</i> me 5 ☐ Resident 28d. Describe how		wat scene
Division		Certification:	3 Suicide 6 Could no 4 Homicide determin	28e. Place of	Injury - At home, farm, st. etc. (Specify)	reet, factory, office	i	28f. Location (Stre City or Town,	et and Number or Rur State)	al Route Number,
	To the Hospitel or At within 24 hours efter or To the Funerel Directompletely filled in by	edical	(Check only 2 Medicel Ex		est of my knowledge, deat s of examination and/or in stated.	vestigation, in my opir	nion, death occurre	ed at the time, date	e and place, and due t	o the cause(s)
	To with Toon	W		uld	AGT		G.M.E.		Date signed (Month, ecember 04	
_	10		30. Name and address of person with 2 ABIACL	HH A	7 111		et, Balt	imore, Ma	aryland 21	201
1	Sta Registi		31. Date filed (Mark Day O'ear) 2	004	strar's Signature	Sparks	/			

	· .		For State Registrar	State of M	aryland / Depa <i>Cer</i>	artment of He tificate of D		-	2004	39024
	DI		1. Decedent's Name (First, Middle, La	st)				2. Date of Death Month	Day Year	3. Time of Death
н	Physici /Medio		Donald Eugene B					November	26,2004	12:10 A. <sup>M</sup>
ı	Examin	er	4a. Facility Name (If not institution, giv 6 West Main Stre	et Apt. 4	L	4b. City, Town, or Hancock			4c. County of Dear	on
	Funeral Director		5. Social Security Number 6. S 176/46/7192	ex	ge (In yrs. last birthday) 46 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y March 31,	9. Bin 2007 1958 Pen	hplace (State or Foreign ountry) nsylvania
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Maryl -f ehc	ţō	Maryland Washing	ton		Ha	ncock			1 ⊈ Yes 2 ☐ No
	th the	Director	10e. Street and Number			10f. Zip Code	···· •	10g	. Citizen of What Co	ountry?
	ath wi		6 West Main S				1750		U.S.A.	- Indian
36	irs after de il, or Items xeminer m	by Funeral	11. Marital Status  12 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces  1  Yes 2  If Yes, Give Year or Dates:	No	Was Decedent of His f Yes, specify Cuban	spanic Origin? (Sp i, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	e, etc.
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Itiem 27 is marked other than "natural", or Items 23a or 28a-f ehow other traumatic event, the Medical Examiner must be muffied at	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	l ducation de <i>completed)</i> College (1-4or	(Give life. L	lent's Usual Occupa kind of work done di DO NOT use retired)	uring most of work	ring	b. Kind of Business	
	e filed within al Hygiene. I other than "vent, the Mes		10 17. Father's Name (First, Middle, Last,			Plumber	18. Mother's Nam	e (First, Middle, Ma	Plumbing iden Sumame)	Industry
Maryland	ould be f Mental I Marked of	To Be	Marshall Homer B					Louise R		
lary	2 should be and Mental is marked c	1	19a. Informant's Name/Relationship (						city or Town, State, 2	
6, ≥	permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau ODE.		Ellen Louise Rus 20a. Method of Disposition	sell (Sist	20b. Place of Dispo				ork 11354 c. Location - City or	
Baltimore,	ages int of h t: If ite y or of		1 Durial 2 Cremation 3 \( \) 4 Donation 5 Other (Specific			natory or other place	11000	mber 30		, Maryland
altin	mit. Partme		21. Signature of Funeral Service Licer			. Name and Address			Funeral	
Ä	Per Land		Jeffrey /	Davis						land 21783
ı	Physician		23a. Part1. Enter the disease, or com sheek, or heart failure. List only Immediate Cause (Final disease or condition	plications that cause one cause on each	d the death. Do not entrine. Plastoma M	er the mode of dying Tultifor m	, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death
н	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):					1
		Jer	Sequentially list conditions, if any, leading to immediate cause (Disease or injury	b. Due to (or as	a consequence of):					
	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
8760,	be exe Ician a burial-	al Ex	resulting in death) cast	Due to (or as	a consequence of):					
687	ficate p physics the	edical		_ d						
P.O. Box	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rall director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
	quires that in signed by uld be deta	ğ	Part II. Other significant conditions of	contributing to death	but not resulting in the ur	nderlying cause give	n in Part I.			the cause of death?
Vital Records,	The law reate has bee	Completed						24a. Was an autopsy performe 1 ☐ Yes 2 2	prior to	utopsy findings available completion of cause of 2 ₩ No
Vita	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		Other		h (Check only one)		
of	Phys r this eral dir	To To	1 ☐ Yes 2 X No  27. Manner of Death	28a. Date of Ini	ent 2 ER/Outpatien ury 28b. Time of	t 3 DOA 28c Injury Work	4   Nursing no	ome 5  Residence 28d. Describe how	be 6 Other (Spe injury occurred	city)
ion	Attending I or death. ector: After by the funer	atlor	1 XNatural 5 ☐ Pending 2 ☐ Accident investigatio	n ( <i>Month, Di</i>	ay Year) Injury		? 'es 2 □ No			
Division of	or Atterde lirecton by the	rtifle	3 ☐ Suicide 6 ☐ Could not be determined	286. Place of If	ijury - At home, farm, str tc. (Specify)	eet, factory, office		28f. Location (Stree City or Town, S	et and Number or Ru State)	ural Route Number,
Ω	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical Certification:	29a. Certifier 1 Certifying Pl	nysician: To the besi	of my knowledge, death	n occurred at the time	e, date and place,	and due to the caus	se(s) and manner as	stated.
	the H hin 24 the F mplete	Medi	one) 29b. Signature and title of certifier	and manner s	tated.	29c. License			. Date signed (Mont.	
	T S		Mart. L	Jahn MD		75604			ovember 30,	
	3		30. Name and address of person who	completed cause of 30 West H	death (Item 23a) (Type,	Dei-A)				/
	Sta Registi		31. Date filed (Month, Day) (Com) 0	9 2004 Regis	th Street, I	South )				

State of Maryland / Department of Health and Mental Hygiene 2 0 0 4 39025 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** UMPHRE BROOKS DECEMBER 1 2004 /Medical 4a. Facility Name (If not institution, give street and number)
PLEASAT VIEW NURSING HOME
LHO! BALTMORE NATIONAL PIKE
5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 4b. City, Town, or Location of Death 4c. County of Death Examiner MOUNT AIRY

If Under 1 Year | If Under 24 H

Months Days Hours Mi MARYLAND CARRO 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) JANUARY 12 Birthplace (State or Foreign Country) **Funeral** Months XX M 2□ F Days Min. 217-12-2180 81 Director 12,1923 MARYLAND Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits or 28a-1 show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2☐ No Director MARYLAND CARROLL MT. AIRY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4104 OLD NATIONAL PIKE 21771 UNITED STATES Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1□Yes 2□No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LABORER FARM 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) CHARLES H. BROOKS ZERNIE MINNIE A. FISHER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GAIL JONES/GUARDIAN OF THE PERSON DEPARTMENT OF AGING 20b. Place of Disposition (Warren DER AVENUE, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) CARROLL CREMATION 12/2/2004 HAMPSTEAD, MARYLAND 21. Six ature of Funeral Service Licenses 22. Name and Address of Facility PDC6 91 WILLIS STREET MYERS-DURBORAW FUNERAL HOME, P.A. WESTMINSTER, Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deat Immedia Cause (Final **Physician** disease or condition resulting in death) HOLD /Medical Due to or as a consequence of): Examiner 1100x0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, the attending physician Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ò in the past 12 months? Month Day Year 5 Other (specify) detached ☐ Yes 2 ☐ No 9 Unknown 9 🗖 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, page 2 should be 1 Tes 2 🗆 No 3 Probably 4 Winknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed 2 No 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: 1 ☐ Inpatient ှင 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After 1 Holatural 5 🗌 Pending 1 🗌 Yes within 24 hours after death.

To the Funeral Director: A comulately filled in by the fu death. investigation 2 No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 2 0 29b. Signature and tale of certifier 29c. License number 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 0 9 2004

State of Maryland / Department of Health and Mental Hygienes 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Baker Month Harriet 26,2004 November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Rockville Hospital Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign (Month, Day, Year) | Washington, DC 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🗗 F 79 578-58-9290 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City Town or Location 7 is marked other then "naturel", or items 23e or 28a-f show treumatic event, the Medical Examinat must be notified at 10d. Inside City Limits Director 1 XYes 2 No Montgomery Boyds 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 12609 Deoudes Road 20841 death v USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Drigin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 Specify: 3 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 Is marked other then? College (1-4or 5+) Elementary/Secondary (0-12) 12 Gov't. Tester for Safety US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Willis Jacob Baker Alice Rippon 19a. Informant's Name/Relationship (Type, Print)
Lawrence R. Smith/Representative 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16341 Paulownia Hill Ct., Mt. Airy, Md. 21771 njury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Dec.2, permit. Page Department of Importent: If any injury or once. \*4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2004 Alexandria, Va. 21. Signature of Fun . I Servi x Licensee De Vol and Address of Facility one 2222 Wisconsin Ave., NW., Washington, DC 20007 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute **Physician** myocardia( infarction immodiate /Medical Due to (or as a consequence of): Examiner Coronari Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical the as 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months? 1 Yes 25No Month Year Day 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð dependant Diabetes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? has certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 2 1 Inpatient 2 XER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Certification: 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 🗌 Homicide within 24 hours a To the Funeref D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Camara Z. Kile, D.O. H0051791 November 26, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive Tamara L. Kile, D.D. ROCKVIlle, MD 31. Date filed (Month, Day, Year) State 33. Registrar's Signature DEC 0.9 2004 Registrar

			1 - For Stete Registrer	State of M	laryland / Dep Co	partment of F ertificate of			2004	39027
ı	Physic		Decedent's Name (First, Middle,  MARY E   B					2. Date of Death Month	Day Year	3. Time of Death
	/Medi Exami		4a. Facility Name (If not institution,	give street and number	)	4b. City, Town, o	or Location of Death	November	4c. County of Death	1111
			FENINSULA REGION  5. Social Security Number  6	15 00.0	/ Centre		sbury		Allen	MICO
	Funeral Director		222–34–0851	. Sex 7. A 1 □ M 2 🏋 F	ge (In yrs. last birthda) 55 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) 6–25–194	(ear) 9. Birth Cou	place (State or Foreign Intry) AWARE
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	ocation				10d. Inside City Limits
	Mary e-f sho	to	DELAWARE SUS	SEX		SBORO				1 ☐ Yes 2 ∏ No
	or 286	Funeral Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Cou	intry?
	eath w	erail	102 BRIAR LANE,	OAK MEADON		1996			US	
920	s 1 and 2 should be filed within 72 hours after death with the Maryland If Health and Mental Hygiene. Item 27 is marked other than "natural", or itema 23a or 28e-f show other traumatic event. Ite Medical Exporimer: was be notified at	þ	1 ☐ Never Married 2 📉 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces	? [No	. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 X No	an, Mexican, Puerto  Specify:	ecity Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: W	ican Indian, , etc. HITE
215-0036	natur	eted	15. Decedent's (Specify only highest	Education grade completed)	(Giv	edent's Usual Occup e kind of work done	during most of work	ing 16	b. Kind of Business/Ir	ndustry
2121	filed within Hygiene. other than "ent, II's Mea	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	DO NOT use retired EMAKER	d)		NONE	
	should be filed within and Mental Hygiene. Marked other than matic event, the M	BeC	17. Father's Name (First, Middle, La	st)	110111	HINEK	18. Mother's Name	(First, Middle, Ma		
Maryland	should be not marked our marked o	L P	WILLIAM BAKE					CCA MCDON		
	1 and 2 sho Health and em 27 is ma ither trauma		19a. Informant's Name/Relationship  DONALD M. BL.						city or Town, State, Zip WARE • 1996	
altimore,			20a. Method of Disposition 1 St Burial 2 □ Cremation 3	□Removal from State	20b. Place of Disc	osition (Name of			c. Location - City or To	
III.	t. Partmen		4 ☐Donation 5 ☐ Other (Spe	city)		ematory or other place CHAPEL			EWES, DELA	WARE
Ba	Deporting the control of the control		21. Signature of Fureral	Melson	/ I	TELSON FUN LONG NECK	RD, MILLSE	ORO, DE. 19	9966	
	Physician /Medical Examiner		23a. Part1. Enter the disease of conshock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a	d the death. Do not er ine.  Whe My a consequence of ):  Lacos School	cardiel	and reverse	ron		Approximate Interval Between Onset and Death
), C	icate be executed physician and sthe burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):					
68760,	ate be hysicia the bur	edicai		d						
.O. Bok 6	that the death certific led by the attending p detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of delive Month	ery Day Year
Ω.	w requires that been signed b should be deta	by	Part II. Other significant conditions  Hyps/tens	contributing to death b	out not resulting in the i	underlying cause give	en in Part I.	23e. Did tobac	corúse contribute to the	ne cause of death?
Vital Records,	The law ate has b page 2 sl	Completed	Cury Cane	dinia_				24a. Was an autopsy performed	prior to cor death?	psy findings available inpletion of cause of
	sician certifi rector	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:		ot aci pos Othe	26. Place of Death			
of			27. Man of Death	28a. Date of Inju	ry 28b. Time o	of 28c. Injury	at 2	ne 5 ☐ Residence 8d. Describe how i	e 6 □Other (Specify	)
sior	불문조출	catio	1 Natural 5 Pending 2 Accident investigati 3 Suicide 6 Could not		y Year) Injury	M 1 🗆 Y	<br Yes 2 □ No			
Division	itel or Attanus after deat ral Director:	Certification	4 Homicide determine	d 286. Place of Inj building, et				City or Town, Si	ŕ	
	To the Hospitel or At within 24 hours after or To the Funeral Directompletely filled in by	Medical	one)	Physician: To the best aminer: On the basis of and manner sta	r examination and/or in	vestigation, in my op	pinion, death occurre	d at the time, date	and place, and due to	the cause(s)
)	with To		29b. Signature and title of certifier	Bans	and	29c. License		11	Vember 2	
9	N 8		30. Tame and address of person who	. 1) and	eath (Item 23a) (Type,	Print)	u. Ink	11.0.	Salishuy A	11/2/0-2
	Sta Registr		31. Date filed (Month, Day, Year)  NOV 2 4	32 Junistra	SMA Del	maralten &	WE I VION	1. Hadst -	Patisbury	1421805
-		-		- Contraction	N 14	PARKET.				

			1- For State of Registrar	Maryland / Departmen <i>Certificat</i>	t of Health and Me e of Death	ental Hygien Reg. N	2001.	39028
4	1	dical	Decedent's Name (First, Middle, Last)     C	R, Ball	Or d	2. Date of Death Month D	year  1 004  c. County of Death	3. Time of Death  1920 M
	Funer Directo		PRMC Hospita	Age (In yrs. last birthday)  Yrs.  H Under Months	ishury	3. Date of Birth	Viconii	place (State or Foreign
	death with the Maryland ms 23a or 28a-f show frougite and the	Director	10a. State 10b. County  Md. Wi(Omi(O)	10c. City, Town or Location	1		1	0d. Inside City Limits
	sath with thes 23a or 26	eral Dire	10e. Street and Number  428 - Cartwright A	10f. Zip	21826		itizen of What Cour	7.
	5-0036 72 hours after death with the Marylar "natural", or Items 23e or 28e-1 show clical Examilies of at	by Funeral	11. Marital Status  1. Never Married 2 Married  3 Widowed 4 Divorced  1. Wes Decede Armed Force 1 Yes 2 If Yes, Give/Year or Date	es? If Yes, soed	lent of Hispanic Origin? (Specify Cuban, Mexican, Puerto Ri	ity Yes or No- can, etc.)	14. Race - Americ Black, White, Specify:	etc.
		Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4)	life. DO NOT us	k done during most of working	16b.	Kind of Business/Ind	dustry
	Maryland 212' of 2 should be filed within the and Mental Hyglene. It is marked other than traumatic event, Ira.	To Be C	17. Father's Name (First, Middle, Last) Artie Bullard		18. Mother's Name (	d To	24/0-	
	O - 1 5 5		19a. Informant's Name/Relationship (Type, Print)  19a. Method of Disposition	20b. Place of Disposition (Name	(Street and Number or Rural I	Salish	or flown, State, Zip	21804
	Iltim nit. Par artmen ortant: injury	OUCE.	1 ☐ Burial ☐ Cremation 3 ☐ Removal from Sta  '4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	(00/SP 51) G (22. Nome and	and the soft acility	-04 G	rdletre	md.
	Ba perr Dep Imp	ä	23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	sed the death. Do not enter the mode	aballa Streat	Salish respiratory arrest,	ery, Au	Approximate Interval Between Onset and Death
35.8	Pnysicia /Medica Examine	al	Immediate Cause (Final disease or condition resulting in death)  a	as a consequence of):	diomy apathi	7		Onset and Death
1-42-51	8760, cate be executed by sician and the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	as a consequence of):				
ind i	O. Box 6 the death certification of the attending processing of the attending processing the control of the con	Completed by Physician/Med		2 Fetal death 3 Ectopic pre t at time of death 5 Other (spe			23d. Date of delive Month	ry Day Year
Ballar	Records, P. he law requires that a has been signed b	ed by PI	Part II. Dther significant conditions contributing to death	n but not resulting in the underlying ca	use given in Part I.		use contribute to the	e cause of death?
e,						24a. Was an autopsy performed? 1 Yes 2 No	death?	sy findings available opletion of cause of
starlet	Division of Vital To the Hospital or Attending Physician: T within 24 hours after death To the Funeral Director: After this certificat completely filled in by the funeral director, pa	Certification; To Be	25. Was case referred to medical examiner?  1	njury 28b. Time of 28b. Time of Injury M	c. Injury at 28d Work? 1 Yes 2 No	5 ☐ Residence d. Describe how inju	6 ☐ Other (Specify, in occurred and Number or Rural	
5	Div Hospital or / 24 hours after Funeral Dira		Duilding,  29a. Certifier  12 Certifying Physician: To the be	etc. (Specify)	t the time, date and place, and	City or Town, State	and manner as also	tod
	To the H within 24 To the F complete	Medical	(Check only one)  2 Medical Examiner: On the basis and manner  29b. Signature and title of certifier	29c.	License number	29d. Da	d place, and due to te signed (Month, E	
			30. Name and address of person who completed cause of Anthony FIM, M.O.	of death (Item 23a) (Type, Print)	0053394 T. sacisbu	ry mo	17/04	
	S Regis	tate strar		strar's Signature	outs			

			1- For State of Maryland / Dep	partment of Health and Nertificate of Death	Mental Hygie	2004	39029
			1. Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year	3. Time of Death
	Physici /Medio		Margaret Ann Boyer		November		3:18 a M
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	th
			414 Belton Court	Silver Spring		Montgom	erv
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda		8. Date of Birth (Month, Day, Ye		hplace (State or Foreign
	Director		216-44-9902 1 M 2X F 78 Yrs.		July 21,		hington, DC
	pu 🛾		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	sho	'n	Tod. State	Location			1 ☐ Yes 2X No
	Sa-f	Director	Maryland Montgomery Silver	***			
	with t	늄	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Co	ountry?
	within 72 hours atter death with the Maryland ene. then "natural", or Items 23a or 28a-f show fra Medical Exeminar must be notified at	Funeral	414 Belton Court	20901		USA	2 - 1 - 4
	ltem Per de	n.	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2/3⊼No	<ul> <li>Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto</li> </ul>	Rican, etc.)	14. Race - Ame Black, White	
36	rs aft	by F	3 ☐ Widowed 4 ₺ Divorced Year or Dates:	1 ☐ Yes 2 🖾 No Specify:		Specify: WI	nite
<b>Ş</b>	hou tura	ed		edent's Usual Occupation	16h	. Kind of Business/	Industry
Maryland 21215-0036	in 72 an" r	Completed	(Specify only highest grade completed) (Giv	re kind of work done during most of work  DO NOT use retired)	ring	. Ithiu of busiless	madstry
2	with iene.	E G	Elementary/Secondary (0-12) College (1-4or 5+)	brarian	N	arral Trate	elligence
0	filed Hyg othe ent,	BeC	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid		stridence
a	ld be ental ked ic ev	To B	John D. Fitzgerald. Sr.	Madaa N	foo Manill		
3	shound M	-		ling Address (Street and Number or Rur	lae McMill al Route Number, Cit	_	Zip Code)
Ž	nd 2 allth a 27 lg		John L. Boyer/ Son 414	Belton Court, Silv	er Spring	MD 2090	0.1
ନ୍	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23a or 28a-f show any njury or other traumatic event, the Medical Examinar must be notified at once.		20a. Method of Disposition 20b. Place of Dis	position (Name of	Date 20c.	Location - City or	
Ê	d = = 50		Gate o	of Heaven	ber 27 004 Sil	ver Sprir	ng, Maryland
Baltimore,	ortan ortan		Ceille	tery 22. Name and Address of Facility rancis J. Collins			ig, naryrana
ä	Degram Personal Perso		J. Kein Stiles	Tancis J. Collins OO University Blvd	Funeral H L. W. Silv	ome Inc er Sprinc	r. MD 20901
			23a. Part1. Enter the disease, or complications that caused the death. Do not e			-r -pring	Approximate
u	The states		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final				Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)  Metastatic Cance  Due to (or as a consequence of):	r			Months
	Examiner		Monkol Coll Conn			9	
		ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	er			Months
	uted d ansit	Examiner	Cause (Disease or injury that initiated events c.				
Ć.	exec in an ial-tr	Exa	resulting in death) Last Due to (or as a consequence of):				
760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Icai	d				
9	iffical g phy as th	ed					
Вох	eath certitic attending p	2	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	C tania susana		23d. Date of deli	very
œ.	death e atte	Physician/Med	1 Ves 2 No. 4 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year
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ιή.	res that igned b	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
Ď	w require been się should b		Anemia		1 🗋 Yes	2 □ No 3 □ Pro	obably 4 XUnknown
Records,	aw re	plet			24a. Was an	24b. Were au	topsy findings available
Ä	The lav	Completed			autopsy performed′ 1 ☐ Yes 2 🛣	?   death?	completion of cause of
Division of Vital		Be C	25. Was case referred to medical	26. Place of Deat	h (Check only one)		32
>	Physician: this certitic al director,	To E	examiner?  1 Yes 2X No  Hospital: 1 Inpatient 2 ER/Outpatient	ent 3 DOA Other: 4 Nursing Ho	me 5XXResidence	6 ☐Other (Spec	rify)
0	ding Ph h. Atter th funeral		27. Manner of Death 1X Natural 5 ☐ Pending (Month, Day Year) 1 Injury 1 In	of 28c. Injury at	28d. Describe how in		
<u> </u>	ath. ath. or: At	atic	2 Accident investigation	M 1 Yes 2 No			
<u>\<u>\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ </u></u>	r Attencer death rector: by the	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury · At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, Str		ral Route Number,
	spital or ours afte oeral Dire	Cer				•	
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely tilled in by the	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, nvestigation, in my opinion, death occurr	and due to the cause red at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	To th withir To th somp	Me	29b. Signature and title of certifier	29c. License number	29d. [	Date signed (Month	, Day, Year)
	(0)		Myma	D32332	No	vember 2	2, 2004
	(0		30. Name and address of pe on who completed cause of death (Item 23a) (Type	, Print)			
				a Ave., #220, Silve	er Spring,	MD 2090	2
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
	Registr	ar	NOV 23 2004 Senera &	sports.			

State of Maryland / Department of Health and Mental Hygiene Reg. No. 004 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death NOVEMBER 21, 2004 **Physician JACOBO** BOLDMAN 2:00 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MARINER HEALTH **BETHESDA** MONTGOMERY 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) MAY 25, 19 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1X M 2□ F 583-12**-**1395 80 Director ARGENTINA Usual Residence of Decedent the Manyland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla artment of Health and Mental Hygiene. ortant: if item 27 is marked other than "natural", or itame 23a or 28a-f show fortant: if item 27 is marked other than "Natural", or item 23a or 28a-f show injury or other traumatic event. It is Medical Evantinar must be notified at 18. 1 ☐ Yes 2 ☐ No Directo MARYLAND MONTGOMERY N. BETHESDA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10201 GROSVENOR PLACE, #606 20852 Funeral UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ☐Yes 2 Yes, Give 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ¥ Yes 2 □ No 2 3 ☐ Widowed 4 ☐ Divorced Year or Dates ARGENTINIAN WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 BUSINESSMAN FOOD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be ABRAHAM BOLDMAN ANA BELFOR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 140 KILSYTH ROAD, #2 BRIGHTON, MA CLAUDIA BOLDMAN, DAUGHTER 02135 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ₺ Burial 2 □ Cremation 3 □ Removal from State 4 □ Dogation 5 □ Other (Specify GARDEN OF REMEMBRANCE 11/24/2004 CLARKSBURG, MARYLAND permit. Departr Importu any Injy 21. Signalure of Fineral Service Lice 22 Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. Jarres 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ACUTE MYELOCYTIC LEUKEMIA MONTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner Cause (Disease or injury that initiated events resulting in death) Last the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760 the attending physician Physiclan/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy jo Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ OBSTRUCTIVE UROPATHY 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy perforn certificate 2 X No 1 🗌 Yes 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 70 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 □Other (Specify) this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27, Manner of Death 28d. Describe how injury occurred After Certification: 1 XNaturat 5 Pending investigation within 24 hours after death. To the Funaral Diractor: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide filled 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) reman, M.D D36552 NOVEMBER 22, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 50 W. EDMONSTON DRIVE, PANKAJ TALWAR, M.D., SUITE #401 ROCKVILLE, MARYLAND 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2004 Registra

State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month HARRIS J. BELMAN NOVEMBER 18, /Medical 2004 8:00 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 10404 STRATHMORE PARK CT., APT. 402 N. BETHESDA MONTGOMERY 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1**X** M 2□ F 213-40-1334 Director 61 FEB. 12, 1943 MARYLAND Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importents: if item 27 is marked other than "naturei", or iteme 23a or 28e-f show any injury or other treumatic event. The Medical Examiner must be notified at once. 10d. Inside City Limits 1 X Yes 2 □ No MARYLAND MONTGOMERY Directo N. BETHESDA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10404 STRATHMORE PARK CT. APT 402 Funeral 20852 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: WHITE 3 Widowed 4 Divorced ieted Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Comple Elementary/Secondary (0-12) College (1-4or 5+) 4 MARKETING EXECUTIVE B A E SYSTEMS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be EDWARD MALIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10404 STRATHMORE PK. CT., APT.402, N. BETHESDA, MD ELAINE F. BELMAN/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) JUDEAN MEM. GARDENS 11/21/2004 OLNEY, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 Umaxda 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician a MULTIPLE MYELOMA disease or condition resulting in death) 3 YEARS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): ician and burial-transit Hoepitel or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. by director, page 2 should 1 ☐ Yes 2 💢 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 X No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5X Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a

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completely filled i tX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title of certifier 2 29c. License number 29d. Date signed (Month, Day, Year) 12 D29675 NOVEMBER 19, 2004 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) RALPH V. BOCCIA, M.D., 6420 ROCKLEDGE DR. #4100, BETHESDA, MD 20817 31. Date filed (Month, Day, Year) 32. egistrar's Signature NOV 23 2004 Registrar carker

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e, Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mantal Hygiene. Item 27 is markad other then "natural", or itams 23a or 28a-f show other traumatic event, Ite Medical Evarimer must be notified at	To Be Completed by Funeral Director	10a. State 10b. County  Maryland Montgom  10e. Street and Number  10000 Brunswick L  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Edi (Specify only highest grace  Elementary/Secondary (0-12) 12  17. Father's Name (First, Middle, Last)  Robert W. Baldwin  19a. Informant's Name/Relationship (T. Robert S. Baldwin	ery  ane, Apt. 5  12. Was Decedent Eve Armed Forces?  1	16a. Decec (Give life. L Bus 19b. Mailin	Spring  10f. Zip Code  20910  Nas Decedent of H 1Yes, specify Cuba  1  Yes 2 No  lent's Usual Occup kind of work done of DO NOT use retired  5  Driver  g Address (Street a	during most of worki	ecify Yes or No-Rican, etc.)  ing  ing  if (First, Middle, Mach Weal Route Number,	Black Specify 6b. Kind of Bu Pranspon Raiden Surname Reden City or Town, S	what Coun  - America k, White, a  White siness/Ind  rtati e)  State, Zip	an Indian, etc.  ustry  On	ity Limits 2%∏ No
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ŀ	Funeral Director		5. Social Security Number 6. Sex 1 C	7. Age (In yrs. last birthd	Months Davs Hou	ours Min. 8. Date of Birth (Month, Day, June 17,	O Rightplace /Ctate or Famige
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11	Sta	te	LINDA M. JEFFE  31. Date filed (Month, Day, Year)	RSON MD 3075 L3	LVINGSTON RI	D. STE 2 BRY	ANS RD. MD. 20616
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 0615 M **Physician** Fecility Name (Ill.not institu 200 /Medical 4b. City. Town, or Location of Death Examiner 5. Social Security Number **Funeral** 6 Sax 7. Age (In yrs. last birthday Date of Birth (Month, Day, Birthplace (State or Foreign Country) Year) 1 □ M 2 🕱 F Director 220-28-0860 76 Jan. 2. 1928 MD Usuel Residence of Decedent with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show traumatic event, the Medical Examiner must be notified at Director MD Anne Arundel 1 ☐ Yes 2 No Annapolis 10f. Zip Code 10g. Citizen of What Country? The Annapolitan 84 North Old Mill Bottom Road Itams 23e 21401 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.

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Yes 212No aneun 1 Yes 2 No 1 Yes funeral director, . Was case referred to medical examiner? 26. Place of Death Check onl one 1 ☐ Yes 2 No Other: Certification: To Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ate of Injury (Month, Day Year) 27. Manner of Doath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident 24 hours after death e Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the To the 29b. Signature and tille of certifie 29c. License number

Registrar
DHMH 17 Rev 1/2001

of verson who completed cause \ death (Item 23a) (Type, Print)

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Tidewater Colonia

			1 For State	State of Marylan			of Health and	Mental Hygie		20025
			Registrar  1. Decedent's Name (First, Middle, Las:	1)	Cei	uncate	or Death		NZ U U 4	39035
ı	Physici	an	Ruth Myrtle Pain	•					Day Year	3. Time of Death
	/Medi		4a. Fecility Name (If not institution, give			41. Ch. T.	wn, or Location of De	November	3 2001	3:20 p M
	Examir	ıer	2 W. East Street	street and number,				atn	4c. County of Death	
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs.	last birthday)	Del:		rs. 8. Date of Birth	Wicomic	
	Director		183-16-6587	□M 2131F 89	Yrs.	Months D			1015 Pop	place (State or Foreign ntry) nsylvania
	p.		Usual Residence of Decedent					oan. Ji,	IJIJ   I EII	nsyrvania
	how thow	_	10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	8a-f	Director	Maryland Wicon	nico D	elmar					1 Yes 2 No
	with th	Dir.	10e. Street and Number			10f. Zip Co	de	10g.	Citizen of What Cou	ntry?
	s 23	rai	2 W. East Street			218			U.S.A	
	ter de	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U. Armed Forces?	S. 13. V	Vas Decedent Yes, specify	of Hispanic Origin? Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Ameri Black, White,	
386	irs af	by	3⊠ Widowed 4 □ Divorced	1 ☐ Yes 2 ∰ No If Yes, Give Year or Dates:	1	☐ Yes 2🛭	No Specify:		Specify:	White
Maryland 21215-0036	within 72 hours after death with the Maryland ene. then "natural", or items 23s or 28s-f show the Mudical Evaminar must be notified at		15. Decedent's Edu	ication	16a. Deced	lent's Usual O	ccupation	166	. Kind of Business/In	White
215	hin 7	Completed	(Specify only highest grad	(e completed)  College (1-4or 5+)	(Give . life. [	kind of work d OO NOT use re	one during most of w etired)	rorking		odstry
21	d wit	NO.	cionionaly/obosinally (o 12)	3	Reg	istere	d Nurse		Hospital	
nd	be filed tal Hygid d other event, I	Be (	17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle, Maid		
yla	should to marked umatic e	ဥ	Harry Elsworth Pa	inter			Mary T	heresa Eich	ner Paint	er
lar	2 she and is m		19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mailin	g Address (St	reet and Number or i	Rural Route Number, Cit	ty or Town, State, Zip	Code)
	1 and 2 Health tem 27			daughter)		East S		Delmar, MD	21875	
Ö	Pages 1 nent of H int: If ite		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐ F		ace of Dispos emetery, crem	sition (Name of natory or other	place)	Date 20c.	. Location - City or To	own, State
Baltimore,	t. Partmentment		'4 □Donation 5 □Other (Specify)	,,,,,		ens Cen		23, 2004 De	lmar, Del	aware
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or othar treumatic event, the Mudical Examiner must be notified at once.		21. Signature of Funeral Service Licens		SI	nort Fu	ddress of Facility ineral Hom	ie		
			23a Part Foter the disease or comple	ications that caused the death	13	3 E. Gr	ove St.	Delmar, DE	19940	
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final	ne cause on each line.	. Do not ente	i the mode of	dying, such as cardi	ac or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)	Lung	00	now	\			2415
*	Examiner			Due to (or as a cone)	ence of):					
- 49		je l	if any leading to immediate	Due to (or as a cons ∗ u	ence of					
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
o,	e exe	EX	resulting in death) Last	Due to (or as a consequ	ence of):					
8760,	cate be executed physician and the burial-transit	Physician/Medical		1						
9	eath certific attending p	Med	IF FEMALE:							
Вох	ath co	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal	death 3 □	Ectopic pregna	ancy		23d. Date of delive	,
0	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown	ath 5□	Other (specify	/)		Month	Day Year
۵.	The law requires that the death certific te has been signed by the attending page 2 should be detached for use as		Part II. Other significant conditions cor	ntributing to death but not resul	lting in the un	derlying cause	given in Part I	23a Did tobacc	o use contribute to th	o source of death?
ds,	w requires that s been signed t should be det	P	Hy sendens	`		2011 y 11 y 00000	gwon in raici.		2 No 3 Prob	
Õ	w req beer shou	iete	0.6							
Vital Record	The lay	Completed	1) (425 25)					24a. Was an autopsy performed?	prior to con	osy findings available npletion of cause of
ta		ပိ	25. Was case referred to medical				00 Bl ( 0	1  Yes 2		2□ No
	yaician: IIS certifica director, J	0 8	examiner?	lospital: 1 □ Inpatient 2 □ E	R/Outpatient	3□ DOA		Home 5 sidence	C 170th /0	,
0	ding Ph. h. After the	L iii	27. Manner of Death		28b. Time of	28c. li	njury at	28d. Describe how in	jury occurred	
Division of	ttendir death. ctor: Af y the fur	atic	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(NOTATI, Day 16al)	Injury		Work? I□Yes 2□No			
ž	irector by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, stre	et, factory, offi	се	28f. Location (Street a	and Number or Rural	Route Number,
	urs af urs af ural D								•	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier   1   Certifying Physical Check only one)   Medical Examination	sician: To the best of my knowner: On the basis of examination	ledge, death on and/or inve	occurred at the	e time, date and plac ny opinion, death occ	e, and due to the cause urred at the time, date a	(s) and manner as sta	ated.
	o the ithin 3 o tha	Mec	29b. Signature and title of certifier	and manner stated.			ense number		ate signed (Month, D	
	- s + ŏ			2			_	250. 0	J/	oy, rear/
	1 -	+	30. Name and address of person who co	moleted cause of death (item)	23a) /Tune B	Robei	et Branton	11	/22/ac	roy
	10.0			or death (moth	(1700, 1	11.157		/	/	
	mf		2 1	D. 500	100	9		140	2180 1	
	Stat Registra	e	31. Date filed (Month, Day, Year) 2 2	00 32. Registrar's Signatu	109 B	Lon	el.3500	y mo	2180/	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death NOVEMBER 17, 2004 **Physician** SARAH CLERMAN 1:00 A. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY GENERAL HOSPITAL MONTGOMERY OLNEY 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) Funeral 9. Birthplace (State or Foreign 1 M 2 F Director Yrs 273-05-3274 APRIL 16, 1922 RUŚSIA Usual Residence of Decedent with the Maryland 10a. State 10b. Count 10c. City, Town or Location Item 27 is marked other than "neturel", or iteme 23a or 28e-f show other treumatic event, the Mudical Examiner must be notified at 10d. Inside City Limits 1 ☐Yes 2√2 No Directo MARYLAND MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 3310 N. LEISURE WORLD BLVD., #209 UNITED STATES death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "neturel", or ite 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify: 3 ₩ Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) KRAVITZ **TSADORE** 'unascertainable' 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Importent: If Item 27 is meny Injury of other treum any Injury of other treum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STEVEN H. CLERMAN, SON 8709 TRYAL COURT, MONTGOMERY VILLAGE, MD 20886 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 X Removal from State KING DAVID MEM. GDN. 11/19/2004 FALLS CHURCH, VA 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC Donald. 170 KOCKVILLE PIKE, ROCKVILLE, MD 23a. Part1. Enter the disease, or complications that caused the a ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Physician OBSTRUCTIVE PULMONARY DISEASE disease or condition resulting in death) CHRONIC 15 YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): ed by the attending physician and detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, PULMONALE, DIABETES MECLITUS, HYPERTENSION 1 XYes 2 No 3 Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed? 1 Yes 2 🗌 No 1 Yes 25 No Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No this 1 ☑npatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation М 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Eilere Mane - Mouriloric D0058542 NOV 17, 2004 D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEDINA HOMELLOVIC 11501 GEORGIA WHEATON, AVENUE 20902 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 23 2004 Registrar Darks!

			1 - For State Registrer		Maryland / De C	partment <i>ertificate</i>	of H	ealth a	and M	lental Hy	/giene	2001	39037
	Physic /Medi	cal	Decedent's Name (First, Mid ADELATOE ETH)     As Escilible Name (If set institute)	EL DOLAN		1. 0				2. Date of De Month 11	22 Dey	2004	3. Time of Death 9:50a <sup>M</sup>
	Exami	ner	4a. Facility Name (If not institut.  Hartley Hall I  5. Social Security Number	Nursing Home	ir) Age (In yrs. last birthdi	4b. City, To	noke	e Cit	У	0.00 (8)	Wo	rceste	r
	Funeral Director		055-10-8463 Usuel Residence of Decedent	1□ M <b>2</b> C F	90 Yrs	Months [	Days	Hours	Min.	8. Date of Bi Month, Di 4/14/1	914	Ne	thplace (State or Foreign ountry) W Jersey
	ith the Marylan or 28a-f show	ctor	VA ACCOR		10c. City, Town or Greenbac								10d. Inside City Limits 1 ☐ Yes 2 No
	ath with th s 23e or 24 rust be ru	Funeral Director	10e. Street and Number 2360 Spinnake			10f. Zip Ci	56					on of What Co USA	ountry?
9036	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Menial Hygiene. Item 27 is marked other then "natural", or Items 23a or 28a-1 show other traumatic event, the Medical Examinar must be a diffied at	þ	11. Marital Status 1 □ Never Married 2 ☒ Ma 3 □ Widowed 4 □ Divorce	If Yes Give	s? ⊈No	3. Was Deceder If Yes, specify 1 ☐ Yes 2 ☐		panic Orig , Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)		Race - Ame Black, White pecify:	
21215-0036	i within 72 hu iene. r <b>than "natu</b> ine Medical	Completed	15. Decede (Specify only high Elementary/Secondary (0-12) 12	ent's Education lest grade completed)  College (1-4o	r 5+)	cedent's Usual C ve kind of work of DO NOT use	done du retired)	tion <i>Iring</i> most	of worki	ng		of Business/	,
Maryland 2	should be filed and Mental Hyg marked other umatic event,	To Be C	17. Father's Name (First, Middle John Maloney	e, Last)				Anna	С	(First, Middle) ampbel	, Maiden S	umame)	
	ss 1 and 2 shi of Health and item 27 is m r other traum		James Dolan  20a. Method of Disposition	hship (Type, Print) husband)	236	oiling Address (S Spinna Rossition (Name)	ker	St.	, Gr		<ville< td=""><td>e, VA</td><td>23356</td></ville<>	e, VA	23356
Baltimore,	t. Page dment o rtant: If njury or		1 ☐ Burial 2 🍎 Cremation 1 ☐ Donation 5 ☐ Other ( 21. Signature of Fundral Service	(Specify)	Salisbury	Cremator	У	1	1/23	/2004	Sal	isbury	
Ä	permi Depa Impo any ir		23a. Part 1. Enter the disease, shock or head failure. I	or complications that cause st only one cause on each	ed the death. Do not e	22. Name and A HOLLOWAY 103 Lind Inter the mode o	<u>ien</u>	Ave.	, PO	comoke	City	P.A. MD 21	Approximate
}	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a	s a consequence of):	in							Interval Between Onset and Death
8760,	death certificate be executed be attending physician and defor use as the burial-transit	icai Examiner	Sequentially list conditions, if any, loading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequence of):		-						
O. Box 6	death certifi e attending id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	□Ectopic pregn					230	d. Date of delik Month	veny Day Year
Δ.	w requires that the been signed by th should be detache	by	Part II. Other significant condit	ions contributing to death	but not resulting in the	underlying caus	e given	in Part I.			obacco use		the cause of death?
	The law ate has b page 2 sl	Completed							_	24a. Was autop perfor 1 Yes	sy	24b. Were aut prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of
	di is	Certification; To Be	2 0 7 100 100 11	Hospital: 1 ☐ Inpat  28a. Date of Inj (Month, Di igation		of 28c.	Other: Injury a Work?	4 Nurs	sing Hom	(Check only on the 5 ☐ Resid 8d. Describe h	lence 6		(fy)
Divi	Hospital or Attendi 24 hours after death. Funeral Director: A stely filled in by the ft		4 Homicide determ	mined 286. Place of In building, e	jury - At home, farm, s tc. (Specify)					City or Tow	m, State)		al Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medicai	29a. Certifier 1 ★ Certifyi (Check only one) 2 ★ Medice 29b. Signature and title of certifier	ng Physician: To the best I Exeminer: On the basis of and manner s	of examination and/or i	th occurred at the nvestigation, in r	ny opin	ion, death	place, a	d at the time, o	date and pla	d manner as s ace, and due t igned (Month,	o the cause(s)
7 1	1 ~		30. Name and address of person	who completed cause of	death (Item 23a) (Type	Print)	57	145	2_	) 0	11.	- 22	40-
	Sta Registr		31. Date filed (Month, Day, Year		rar's Signature	Derint)	UK	e,	MJ	21	851		
	riegisti	М	310 V 20	- Loui June	10 10 19								

			1- State of Registrar	f Maryland / Dep <i>Ce</i>	artment of Hea <i>rtificate of De</i>		ental Hygier Reg. 1		
	Physic /Medi		Decedent's Name (First, Middle, Last)     NORMAN ROBERT LEE DAVIS				2. Date of Death	Day Year 3 im	<b>⊕</b> 8 56 p <sup>M</sup>
	Exami		4a. Facility Name (If not institution, give street and num		4b. City, Town, or Loc	ation of Death		4c. County of Death	<del>У</del> ОР
			CIVISTAL MEDICAL CE.  5. Social Security Number 6. Sex		LAPLATA	Under 24 Hrs. T.		CHARLES	
	Funeral Director		408-34-9505 <sup>1</sup> X <sup>M 2□ F</sup>	7. Age (In yrs. last birthday)  79  Yrs.		ours Min.	B. Date of Birth Month, Day, Yes JUNE 5, 192	9. Birthplace (State Country) NORIH CAROLI	or Foreign NA
	show		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside 0	City Limits
	death with the Maryland ms 23a or 28a-f show must be notified at	to	MARYLAND CHARLES	MARBU	RY				s 2 □ No
	ith the M or 28a-1 s rotifie	Director	10e. Street and Number		10f. Zip Code		10g. (	Citizen of What Country?	
	23a c	la D	5650 TRIANGLE LANE / P.O	. BOX 114	20658		UNI	TED STATES	
36	or ite	by Funeral	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Dece Armed For In Yes, Giv.	2 XINO	Was Decedent of Hispar If Yes, specify Cuban, M 1 ☐ Yes 2 No Sp	nic Origin? (Speci lexican, Puerto Ri pecify:	ify Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc.  Specify: BLACK	
9	72 hours "natural",	ted	15. Decedent's Education	16a. Dece	dent's Usual Occupation		16b.	Kind of Business/Industry	
Maryland 21215-0036	within 7. iene.	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4TH GRADE	-4or 5+) (Give	kind of work done during DO NOT use retired)  STEWARD FOR	g most of working		ONSTRUCTION	
p	be filed tal Hygi d other avant, I	Be C	17. Father's Name (First, Middle, Last)	SHOI			First, Middle, Maide		
ylar	2 should be filed and Mental Hygi Is marked other aumatic avant, I	To B	CLAUDE DAVIS				ENTER DAV		
	ges 1 and 2 should to f Health and Men If itam 27 is marke or other traumatic		19a. Informant's Name/Relationship (Type, Print)  GERTRUDE DAVIS / WIFE		ng Address (Street and N BOX 114 MA			or Town, State, Zip Code) 20658	
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If itam 27 it any injury or othar tre		20a. Method of Disposition 1 ♣ Burial 2 □ Cremation 3 □ Removal from S	20b. Place of Dispo cemetery, crer	sition (Name of matory or other place)	Dat	te 20c.	Location - City or Town, State	
Iţi	artmer artmer ortant injury		' 4 □ Donation 5 □ Other (Specify)  21. Size fure of Funeral Service Livers	PLEASANT GR	OVE CHURCH CEN	1. NOVEMBE	R 27, 2004	MARBURY, MARYLAND	)
Ba	permit. Departi Import any inj	i i	ely mal int	M00583 TH	Name and Address of <b>CRNION FUNERAL</b> 39 LIVINGSION	HOME, P. ROAD, IND	A. IAN HEAD, M	ARYLAND 20640	
	Physician physician and physician and as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.		Infacti		espiratory arrest,	Approximal Interval Bet Onset and	tween
s, P.O. Box 68760,	The law requires that the death certificate be execut ite has been signed by the attending physician and bage 2 should be detached for use as the burial-tran	by Physician/Medical	in the past 12 months?	int at time of death 5 wn	Ectopic pregnancy Other (specify)	Part I.	23e. Did tobacco	23d. Date of delivery  Month Day	Year
rd	w require been sig should b	edt					1 ☐ Yes 2	2 □ No 3 □ Probably 4 Ū	Inknown
al Records,		Completed					24a. Was an autopsy performed?	24b. Were autopsy findings prior to completion of cideath?  1 □ Yes 2 ☑ No	available ause of
Vital	Physician: this certificate al director,	Be	25. Was case referred to medical examiner?		0.4	Place of Death (C			
<del>_</del>	Phys rthis ral di	2	1 ☐ Yes 2 ☑ No 1 ☐ In 27. Manner of Death 28a. Date of	patient 2 FVOutpatien Injury 28b. Time of			5 Residence  1. Describe how inju-	6 ☐ Other (Specify)	
lon	th. : After s funer	tlor	1 Maria 5 ☐ Pending (Month 2 ☐ Accident investigation	, Day Year) Injury	28c. Injury at Work? M 1 ☐ Yes		. Describe now inju	ary occurred	
Division	To the Hospital or Attanding Physician: within 24 hours after death.  To the Funaral Director: After this certific completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be determined 28e. Place of	of Injury - At home, farm, stre g, etc. (Specify)			Location (Street a City or Town, Stat	nd Number or Rural Route Num e)	ber,
	a Hospi 24 hour a Funar letely fills	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the base and manner	is of examination and/or inv	occurred at the time, da estigation, in my opinion	ite and place, and , death occurred	I due to the cause(s at the time, date an	s) and manner as stated. d place, and due to the cause(s)	)
	To th within To th	¥ ■	29b. Signature and title of certifier		29c. License num	ber	29d. Da	ate signed (Month, Day, Year)	
			hel Hale		DH-005	58095	14	n 21.2000	1
()	25			of death (Item 23a) (Type, I			1		r
	Sta	e	HARDY, TONYA, L MD 31. Date filed (Month, Day, Year) 32. P	11345 PEMI distrar's Signature	A	JARE WA	LDORF M	D 20603	
	Registr		NOV 2 3 2004	eque H. A	real s				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 004 39039 For State Registrar AMEND#19bperFH12/3/04, BMW, McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** November 17, 2004 8:50 P M Herbert George Edwards /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1XM 2□F 577-58-4858 67 05/07/1937 Jamaica Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2X No Director Rockville MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 299 Hurley Avenue 20850 Jamaica Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. □Yes 2 No Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Black Specify: Completed by 3 X Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Physician Emergency Room 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Kathina Smith Lindsay Edwards 191 Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Fern Street, NW, Washington, DC, 20012 Marlena D. Edwards, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State Department of Important: If any injury of once. Lincoln Crematory 11/23/2004 Brentwood, Maryland `4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simple Tribute 21 Signature of Funeral 3 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List tinly one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2☐No 3☐Probably 4☐Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy perform 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient Certification: To 1 🗌 Yes 2 ER/Outpatient 3 DOA 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

attending physician and for use as the burial-transit The law requires that the death certificate be executed P.O. Box 68760 Division of Vital Records, page 2 should be Hospital or Attending Physician: funeral director. this After death. hours after deat à 24 hours a within 2. To the I the

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or 28a-f show

ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be rigitled at

or other traumatic

item 27 i

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and 2 should be filed within 72 hours after death leatth and Mental Hygiene. m 27 is marked other than "natural", or Items 23.

Baltimore, Maryland 21215-0036

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DO05 7/24

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Truong Bao, MD, 13219 Executive Park Terrace, Germantown, Maryland 20874

31. Date filed (Month, Day, Year) NOV 23 2004 32. Registrar's Signature oaks

Registrar

2

Medical

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Year JULIA GARDNER EATON November 1 8,2004 0700 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Memorial Hospital Easton
If Under 1 Year | If Under 24 Hrs. | Talbot 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
OCT. 3, 1918 **Funeral** 6. Sex 9. Birthplace (State or Foreign Months Days Hours 1 ☐ M 2 😿 F 86 Yrs. Director 213-01-5676 MARYLAND Usual Residence of Decedent with the Maryland 10a, State 10c. City, Town or Location item 27 is marked other than "natural", or itams 23e or 28e4 show other treumatic event, the Medical Examinating must be notified at 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2 X No QUEEN ANNE'S CHESTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1330 QUEEN ANNE DRIVE 21619 USA Pages 1 and 2 should be filed within 72 hours after death v nent of Health and Mental Hygiene. ent: if item 27 is marked other than "naturai", or itams 23e Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. 1 Never Married 2 Married Eaton Maryland 21215-0036 þ 1 ☐ Yes 2 X No Specify: WHITE 3 Widowed 4 Divorced Specify: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 TOLL COLLECTOR TRANSPORTATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be TILGHMAN OGLE EATON MAGGIE GARDNER 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHAEL R. ROSTER/NEPHEW 102 E. MAIN ST., SUITE 203, STEVENSVILLE, MD 21666 /ulia G.
Baltimore, ! 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permil. Pages 1
Department of H
Importent: if ite
any injury or ot 1 

Burial 2 □ Cremation 3 □ Removal from State \* 4 ☐ Donation = 5 ☐ Other (Specify) STEVENSVILLE CEMETERY 11/20/2004 | STEVENSVILLE, MD Fyneral Service Licensee 21. Signatu 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one can be one each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Respiratory disease or condition resulting in death) SIXday /Medical Due to (or as a cons quence of): Examiner pirallo Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (of as a consequence of): Examiner sician and e burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical KATOUIL vullus ending physical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy ŏ Day Month Year 4 ☐ Pregnant at time of death 5 Other (specify) P.O. I ed by the a 1 ☐ Yes 2 🗷 No 9□ Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by artem disane 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Dinknown peen p (a cemen) 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Heatal Kerne 2 No 1 Yes or Attanding Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death Check onl one Hospital: 1 Anpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28b. Time of After 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be 3 Suicide in by 1 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) 4 Homicide 156 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical ro tha 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11/18/04 D 0046020 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SYED ALI M.D., 506 IDLEWILD AVE., EASTON, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2004 Registrar

		1 _ State	tate of Maryland / D	epartme Certifica				201	nı.	20011
		Registrar  1. Decedent's Name (First, Middle, Last)		Jerunca	le oi D		2. Date of Death	. Notal U	JH	3. Time of Death
Physic		RUTH B. ERLICHMAN					Month	Day	Year	3.4
/Med Exami		4a. Facility Name (If not institution, give street	et and number)	4b. City	/. Town, or L	ocation of Death	OVEMBER	18, 20 4c. County	004	7:18 A <sup>M</sup>
LXailli	1101	SUBURBAN HOSPITAL	·		HESDA					
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birth	day) If Und	er 1 Year	If Under 24 Hrs.	9 Date of Birth	MONTGO	9. Birthol	ace (State or Foreign
Director		577 <b>-</b> 60-1733 <sup>1□ M</sup>	280 F 85 Y	rs. Months	Days	Hours Min.	06/11/19	19	Coun	INGTON DC
pu .		Usual Residence of Decedent  10a. State 10b. County	100 City T							
aryla •hov	7		10c. City, Town	or Location					10	Od. Inside City Limits
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ryli hould d Mei mark mark	2	SAMUEL  19a. Informant's Name/Relationship (Type, 1	BAUMAN	Asilina Adda		NNA		POLLAC		
Ma d 2 s th an t7 is 1		JEFFREY ERLICHMAN/SO				d Number or Rural				
Te, 1 an Heal		20a. Method of Disposition	20b. Place of I	Disposition (Na	ime of	LN., BR		E MD		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28e-1 show any nigury or pother treumatic event, tre Madical Examiner must be notified at angines.		1 X Burial 2 ☐ Cremation 3 X Remo '4 ☐ Donation 5 ☐ Other (Specify)	wai irom State	crematory or		0 11/01			,	
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Division of  Division of  To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check only 2 Medical Examiner:	n: To the best of my knowledge, on the basis of examination and/	death occurred or investigation	at the time, n, in my opini	date and place, an on, death occurred	d due to the cause at the time, date	e(s) and man and place, ar	ner as stat nd due to t	ted. he cause(s)
o the	Me	29b. Signature and title of certifier	and manner stated.	/ 2 29	c. License nu	ımber	29d.	Date signed	(Month. Da	av. Year)
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3		30. Name and address of person who complete	eted cause of death (Item 23a) (To	rpe, Print)	-	,			,	D 20852
		Patricia Tomsko	Nay, 11/19 Ro	ckui	HE P	Ke, 6-16	Do, Roc,	KVIII	e, Mi	020852
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	Funeral Director		220al 36wi0 578ar 6. Sr 220-36-1576 1 Usual Residence of Decedent	HSPKI'N F ax 7. Age (In yrs. □ M 212 F	last birthday)  3 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Y	A11 1	Birthplace (State or Foreign Country) Navyland
	Maryland f show		10a. State 10b. County		ty, Town or Lo					10d. Inside City Limits
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Q	Sa or 2	- Dir	10e. Street and Number 5876 Deey	- Ridge K	load	10f. Zip Code	071	10g	Citizen of What	
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5-0036	"naturel",		3 ☐ Widowed 4 [ Divorced 15. Decedent's Ed	Year or Dates:	16a. Dece	dent's Usual Occupa	ition	16	b. Kind of Busine	ack ess/lodustry
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	and 2 lealth a m 27 is		Shawn	Kane	394	5. Quee	ns Lace		esville	MD. 21208
Baltimore	Pa men ury		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify	Removal from State	emetery, crer Na Me	sition (Name of matory or other place)  Movial Po	rK 11/26	104 B	altim	ore MD
Ba	permit Depart Import any in		21. Signature of Funeral Service Licens	". Devre	O F	HENRY FU	ineral F	tome, P.	A.	MD, 21613 Approximate
İ	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	ne cause on each line.				respiratory arrest	riage	Approximate Interval Between Onset and Death
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Division o	ng Ph fter th neral		27. Manner of Death  1 Matural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. injury Work		d. Describe how i		Journey
DIVI	al or Att s atter d il Direct id in by	Sertifle	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		eet, factory, office	28	f. Location (Street City or Town, St	and Number or late)	Rural Route Number,
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	To t To t	Σ	29b. Signature and title of certifier	7 NS 1.54		29c. License			Date signed (Mo.	
		1	30. Name and address of person who co	MD, MPH	23a) /Tunn 1		-000	No	VEMBER	21,2004
	eccent Annual		DIANA CRAMP	GOD N. WOLF	E ST 1	MARBURG	B 186 BA	LTIMORE	MD	
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н	Physici	an	Decedent's Name (First, Middle, Last)					Date of Death     Month	Day Year,	3. Time of Death
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	Examir	er	4a. Fecility Name (If not institution, give s		4 - 1	_	or Location of Death		4c. County of Deat	
	Funeral		Washington Cour  5. Social Security Number 6. Sex	7 Age	CAL e (In yrs. last birthday)	If Under 1 Year	Hagerstown If Under 24 Hrs.	8. Date of Birth	Washing 9. Birt	
	Director		219/60/4670	M 2□F	51 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye March 18,	1953 Ma:	hplace (State or Foreign untry) rvland
	pu ,		Usual Residence of Decedent  10a. State 10b. County		10-10-2					
	shov	5	10a. State 10b. County  Maryland Washing to	nn l	10c. City, Town or Lo	Hagers	etorm			10d. Inside City Limits 1   Yes 2  No
	28e-f	ecto	10e. Street and Number	711		10f. Zip Code	SCOWII	100	Citizen of What Co	
	with Sa or		815 West Wash	ington S	treet	Tot. Zip Code	21740	109.	U.S	•
	within 72 hours after deeth with the Maryland ane. then "naturel; or itams 23a or 28e-f show ta Madical Examinar musi Le nutilied at	Funeral Director		12. Was Decedent B		Was Decedent of H	Hispanic Origin? (Specian, Mexican, Puerto F	cify Yes or No-	14. Race - Ame	ncan Indian,
9	or its	Fu	1 Never Married 2 Married	Armed Forces?  1 Yes 2000  If Yes, Give	ło	if Yes, sp <i>ec</i> ify Cuba 1 □ Yes XXNo		lican, etc.)	Black, White	
003	urel',	d by	3 Widowed 4 Divorced	Year or Dates:					Specify: W	nite
21215-0036	n 72 h	Completed	15. Decedent's Edu (Specify only highest grade		16a. Dece (Give	dent's Usual Occup kind of work done	pation during most of workin d)	g 16b	. Kind of Business/	Industry
12	withli Bne. then	dwo	Elementary/Secondary (0-12)	College (1-4or 5	+)	aborer	<i>a</i> )		Construc	rtion
þ	illed Hygi other	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, Maid		LION
<u>la</u>	2 should be and Mental Is markad o sumatic eve	To B	Theodore L. For	rest			Irene	e Draper		
Maryland	2 should and Men is marks eumatic		19a. Informant's Name/Relationship (Type	оө, Print)	19b. Maili	ng Address (Street	and Number or Rural	Route Number, Ci	ry or Town, State, Z	lip Code)
	1 and 2 Health em 27 othar tr		Linda L. Forrest	(Wife)			shington St			
Baltimore,	of of		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ R	emoval from State		natory or other place	· DACAMI		Location - City or	Town, State
ij	permit. Pag Department Importent: I any injury o		<ul><li>4 □ Donation 5 □ Other (Specify)</li><li>21. Signature of Funeral Service License</li></ul>		Smithsburg		ory   2	2004 Sm		Maryland
Ba	permit. Departr Importe any inju		21. Signature of Furieral Service License	1) . "		2. Name and Addre	lbury Ave.		Funeral	
	2 5 3		ea. Part1 5 the disease, or compli	cations that caused	the death. Do not ent				ig, nary	Approximate
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	PEG-	romtis					Interval Between Onset and Death
8760,	Examiner	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	a consequence of):  NO COM F (2) a consequence of): a consequence of):	OMIZED	) STA	ZUTH		MHNY YEAR
O. Box 6	The law requires that the death centificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c, If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)	у		23d. Date of deli Month	very Day Year
ecords, P.	quires that in signed b	by	Part II. Other significant conditions con	tributing to death bu	ut not resulting in the u Fみレレ		ven in Part I.	23e. Did tobaco		the cause of death?
00	aw requir is been s 2 should	Completed	CHROMIC STI	= RoiD	VSE			24a. Was an	24b. Were au	topsy findings available
R	The lav	mo;	ADDISONIS SVA	DEDME /	ADREMAL	Î NSU FF	SI CIENCY)	autopsy performed 1 Yes 2	prior to c death? No 1 \(\text{T Yes}\)	ompletion of cause of 2 No
Vital R	ysician: Th is certificete director, pag	Bec	25. Was case referred to medical examiner?	(	717721110	167011	26. Place of Death			
of V	S D	၉	1 Yes No	ospital: 1 X Inpatie			4 Industry Hom		6 Other (Spec	ify)
n c	ding Ph h. After th funeral	inol	27. Manner of Death  Natural 5 Pending	28a. Fate of Injur (Month, Day	Year) 28b. Time of Injury	Wor		3d. Describe how in	jury occurred	~
isi	death death ctor: A y the fu	icat	2 Accident investigation 3 Suicide 6 Could not be	200 Place of Inju	ury - At home, farm, str		Yes 2 □No	of Location (Street	and Number or Ru	m l Bauta Mumbar
Division	f or Attendated after death Director:	Certification:	4 Homicide determined	building, etc		eet, ractory, office	20	City or Town, St	ate)	rai Houte Number,
	To the Hospitef or At within 24 hours after or To the Funeral Direct completely filled in by	Medical C	29a. Certifier (Check only one)	ician: To the best of ler: On the basis of and manner sta	of my knowledge, death examination and/or in ted.	n occurred at the tir vestigation, in my o	me, date and place, ar opinion, death occurred	nd due to the cause d at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	To th within To the compl	Me	29b. Signature and title of certifie	)		29c. Licens	se number	29d. I	Date signed (Month	, Day, Year)
	1		1 (3 )	smour	- MD	Do	06076	1 1:	2/1/20	04
	5		30. Name and address of person who co	mpleted cause of de	eath (Item 23a) (Type,		1	, ,	10.0	,
est 1			Dr. Comani		131 Vas	e Hill	thre	Hag.	Md 21	740
	Sta Registr		31. Date filed (Month, Day, Year)  PFC 0 9 2004	32. Registra	ur's Signature	Ann V.		r		

Baltimore, Maryland 21215-0036

EVERETT C. FLEETWOOD

Division of Vital Records, P.O. Box 68760,

		Decedent's Nam	o (Cime Middle	Lone						0.0-141	neg. No		
Physici	an		tt C. Fl							2. Date of I Month	Da		3. Time of Death
/Medic					<del></del>					NOV.		2004	12:15P M
Examin	er			give street and number)		41	b. City, Town, o	r Location	of Death		40	. County of Dea	ath
				g and Rehab	Center					7, Md.	IV.	<i>licomico</i>	
Funeral Director		5. Social Security N		7. Ag 1 2 M 2 ☐ F	e (In yrs. last birt 84		f Under 1 Year Ionths Days	If Unde Hours	Min.	8. Date of E (Month) 01/24/	Birth 71920	9. Bi	nthplace (State or Foreign country) Laware
D.		Usual Residence of	T										
nylan how		10a. State	10b. County		10c. City, Town								10d. Inside City Limits
Ma Hiller	Director	DE	Susse	×	'	Seafo	ord						1 ☐ Yes 2 No
h the	ire	10e. Street and Nu	ımber				10f. Zip Code				10g. Ci	tizen of What C	ountry?
h wii	al	9083 E	Easter L	ane			19	973				USA	
within 72 hours after death with the Maryland one. than "naturel", or Items 23e or 28e-f show he Madical Examinat must be notified at	Funeral	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.S.	13. Was	Decedent of H	lispanic O	rigin? (Spe	ecify Yes or I	No-	14. Race - Am Black, Whi	
or It			ried 2 Marrie		No		Yes 2 No	Specify		7 110411, 010.)		7.71	nite
rel:	d by	3 ⚠ Widowed	4 □Divorced	Year or Dates:		'	765 ZASINO	Specify	,,			Specify: WI	
72 h netu	Completed	(Soe	15. Decedent's	Education grade completed)	16a.	Decedent	t's Usual Occup d of work done	ation during mo	st of worki	ina -	16b. K	(ind of Business	s/Industry
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ygien Per th	Co	8			30	11001	Dus Coi		LOI		11	anspor	tation
ild be file lental Hy rked oth	To Be	17. Father's Name Pau1	(First, Middle, La Fleetwoo					18. Moth		e Mass		Leetwood	1
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "naturel", or Items 23e or 28e-f show any injury or other treumatic event, Ira Madical Examinar must be notified at once.		19a. Informant's N Ronald F					ddress (Street Cannon )					or Town, State,	Zip Code)
s 1 au f Hea item othe		20a. Method of Dis	sposition		20b. Place of	Disposition	on (Name of	1		ate	20c. L	ocation - City or	Town, State
Pages nent of I ant: If it			☐ Cremation 3 5 ☐ Other (Spe	Removal from State	Odd Fe1		ory`or other plac Cemete		11/23	/2004	La	urel,DE	
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permi Depa Impo any i			21 Live	1 1					•	700 W	st S	t., Leu	rel,DE 1995
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/Medical		disease or condition resulting in death)		a. Due to (or as	a consequence of	of):	- 10	9 81	822	na cea			92017
Examiner				Com			6	8 7	-F)-				
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atter for L		23b. Was deceder in the past 12	2 months?	1 ☐Live birth 4 ☐ Pregnant at	2 Fetal death		opic pregnancy her (specify)					Month Month	Day Year
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The cate pag	Cor									1 Yes	formed? 2 PNo	death? 1 ☐ Yes	2 □ No
Physicien: The lav this certificate has al director, page 2	Be	25. Was case reference examiner?	rred to medical					26. Plac	e of Death	(Check only	one)		
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To the Hospitel or Attending Physicien: The law requires that the de within 24 hours after death. To the Funeral Diractor: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached f	Medicai	29a. Certifier (Check only one)	1 Certifying 2 Medical Ex	Physicien: To the best of ceminer: On the basis of and manner sta	examination and	death oc	curred at the timigation, in my or	ne, date a pinion, de	nd place, a ath occurre	and due to the	e cause(s) e, date and	and manner as d place, and due	s stated. e to the cause(s)
Fo th Mithir Fo th comp	×	29b. Signature and	d title of certifier	1 .0			29c. License	e number			29d. Dat	te signed (Mont	h, Day, Year)
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20.0	-	30 Name and add	ress of person w	no completed cause of de	eath (Item 23a) /7	Type Prin	1)	-/-	1	7		1171	9
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State Registrar

31. Date filed (Month NOV 2 2 2004 32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygieney 1 - For Stata Registrar 39045 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day SADIE DORIS FOERSTER November 1421 /Medical 27 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hospital Memorial Easton Talbot If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) JUNE 9 1918 **Funeral** 9. Birthplace (State or Foreign Days Hours 1 □ M **X**XF 86 Yrs. 212-05-2597 Director MARYLAND Usual Residence of Decedent 10a. State orlant: If itam 27 is marked other than "neturel", or itams 23a or 28a-f show in ury or other treumatic event. Its Madical Examinar must be rutified at 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1**7** Yes 2 □ No MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 41 PARK LANE 21601 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ould be filed within 72 hours after Mental Hygiene. 1 Never Married 2 Married Be Completed by If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: WHITE 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If itam 27 is marked other than 1 any in ury or other treumatic event, the Magnin, ury or other treumatic event, the Magnin Elementary/Secondary (0-12) College (1-4or 5+) 11 0 TELEPHONE OPERATOR COMMUNICATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JAMES L. CHIVERAL SARAH J. BURCH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SARAH E. TRICE/GRANDDAUGHTER 7645 HARMONY RD PRESTON, MD 21655 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SPRING HILL CEMETERY 12-2-2004 EASTON, MARYLAND 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 Ostrowski. Joseph 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Gagueritary rist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Ö detached ģ Division of Vital Records, P. signed I conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown peed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 certificate ere brovascular di sease, ance 2 **N**0 Pancer 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: 1 ☐ Inpatient 1 Yes 2 No 2 Other: 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28c. Injury at Work? After 28b. Time of 28d. Describe how injury occurred Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No after death Director: / d in by the f 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To tha Funaral C 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 440Ve 046820 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JENNIFER HOLLYWOOD M.D. 538 CYNWOOD DRIVE, EASTON, MD 21601 Year) 32. Registrar's Signature State Registrar

amend 15-19b per KBH g838 12/9/04

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 39046 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** GARLAND DAESEAN 3:25 AM ELIJAH 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner HOSPITAL CHEVERLY PRINCE CENTER GECKGE 'S PRINCE CHORGE'S If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1⊠M 2□F MD 31-Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County or 28a-1 show the Medical Examiner must be notified at 1 Yes 2 No DISTRICT PRINCE HEIGHTS GEORGE Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. DRIVE GLEN SHADY "natural", or items 23a 1621 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after I □Yes 2 No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No BLACK Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Importent: If item 27 is marked other tren any injury or other traumatic even. Elementary/Secondary (0-12) College (1-4or 5+) Infant Infant 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Chrystal Medley Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1621 shady Glen Dr. Prince George, MD. Chrystal Medley (mother) 20b. Place of Disposition (Name of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify), 21. Signature of F Perty. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or learn failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease) or condition resulting in death) KENAL **Physician** /Medical **Examiner** HEMORRHAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed TREMATURIT) Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, DISTRESS SYNDROME Medical Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 □Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 2 No 1 Yes completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2X No 1 X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After t 1 X Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funerel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 16239

State Registrar

ANTOINE

31. Date filed (METCOa) 19ar 2004

DHMH 17 Rev 1/2001

HOSPITAL

CHEVERLY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FOMUFOD

3001

32 Aggistrar's Signature

			1 - For State Registrer	State	of Mary	land / Dep <i>Ce</i>	artmen ertificat				fental Hy	/gier	201	)4	39	047
	0		1. Decedent's Name (First, Middl	e, Last)							2. Date of D	eath			3. Time	of Death
	Physici /Medi		Nancy Upton G	ogo1							Month Novemb		Day 21.2	Year 004	3:50	a <sub>M</sub>
	Examir		4a. Fecility Name (If not institution	n, give street and n	umber)		4b. City,	Town, or	Location	of Death	1 - 1 - 1 - 1 - 1		4c. County			
			7 Schindler C	ourt			Sil	ver	Sprin	ng			Mont	gome	ry	
	Funeral		5. Social Security Number	6. Sex	7. Age (In	yrs. last birthday		1 Year			8. Date of Bi	rth		9. Birth	place (State	or Foreign
	Director		031-12-4275	1 □ M 2X □ F		79 Yrs.	Months	Days	Hours	Min.	(Month, Di March 2				ntry) '	
	p ,		Usual Residence of Decedent		10	0:5- 7										
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	vith th	Director	10e. Street and Number				10f. Zip	Code				10g. (	Citizen of V	Vhat Cou	ntry?	
	ath v	20	7 Schindler Co				20	903					USA			
	tems	Funerai	11. Marital Status	12. Was De Armed F	orces?	in U.S. 13.	Was Deced If Yes, spec	dent of Hi cify Cubar	spanic Or n, Mexicai	igin? (Spo n, Puerto	ecify Yes or No Rican, etc.)	0-		e - Ameri k, White,	can Indian, etc.	
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21215-0036	d within 72 hours after death with the Maryland jiene. r then "naturel", or Items 23a or 28e-f show the Medical Exeminat must be medified at			Year or the true of true o	Dates:	de D	desate 11									
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Вох	death certifi e attending id for use as	ian/	23b. Was decedent pregnant in the past 12 months?		birth 2 🗌	Fetel death 3	DEctopic pro						23d. Date Mon		ary Day	Year
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		ion	1 Natural 5 ☐ Pendin	9	of Injury oth, Day Yea	28b. Time o		Bc. Injury Work	?		28d. Describe I	now inji	ury occurre	ed		
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Division	or Attendation of Director:	Certification:	4 Homicide determ	ined 286. Placi build	ling, etc. (Sp	At home, farm, str pecify)	eet, factory	, office		2	28f. Location (S City or Tov			r or Hura	i Houte Nur	nber,
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	To the Hospitel or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical one)	g Physicien: To the Exeminer: On the band man	pasis of exar nner stated.	mination and/or in	vestigation,	in my opi	inion, deal	d place, a	ed at the time,	cause(: date ar	s) and man nd place, a	ner as st nd due to	ated. the cause(	s)
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	/		1. 00	- 0-	Ç	A		5437	8			N	ovemb	er 2	2, 20	04
	5		30. Name and address of person	who completed cau	se of death	Atem 23a) (Type	Print)									
			Cheryl Ayleswo				.,	lvd.	#400	0, 1	Wheaton	ı	_ м	ID 20	902	
	Sta	te	31. Date filed (Month, Day, Year)	32. F	logistrar's S	ignature				,			,			
	Registr	ar	WOV 23	2004	epera	29	100	ake	/							

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth DECEMBER 1, Year 2004 6:05PM **Physician** MELANIE ANN HUSSELBAUGH /Medical 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner WESTMINSTER NSG/REHABILITATION CENTER WESTMINSTER CARROLL 8. Date of Birth (Month, Dey, Yeer) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** 9. Birthplace (State or Foreign Deys Hours 1 □ M Yrs. Director 1949 MARYLAND 220-48-4595 Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiane.
Important: If them 27 is marked other than "natural" or health any Injury or other trainment. 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits Director 1 ☐ Yes 2/CXNo MARYLAND CARROLL WESTMINSTER 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 550 MT. HOLLY DRIVE 21157 UNITED STATES Funeral 12. Was Decedent Ever in U,S Armed Forces? 11. Meritel Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Merried 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: þ Specify: WHITE 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) THE ACHER HIGH SCHOOL 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ WILLIAM F. HUSSELBAUGH, JR. AMELIA M. BOSSE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) AMELIA M. MACDERMOTT/MTOHER 550 MT. HOLLY DRIVE. WESTMINSTER, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CARROLL CREMATION 12/3/2004 HAMPSTEAD, MARYLAND 21. Signature of Funeral Service Licen 22 Name and Address of Facility MYERS-DURBORAW FUNERAL HOME, P.A. 91 WILLIS STREET, WESTMINSTER, MD 21157 23a. Pert1. Enter the disease, or complications that was the disal. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Examiner The lew requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of). Box 68760 Physician/Medicai Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. DId tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ Division of Vital Records, paga 2 should 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? After this cartificate has 3/2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: Be 25. Wes case referred to medical 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1□ Yes 2☑No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 27. Menner of Death edical Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Netural eral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide within 24 hours e To the Funeral C Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) POULE WESTMINSTER 31. Date filed (Month, Day, Yeer) 32. Registrer's Signature

DHMH 16 Rev 6/95

State Registrar

DEC 0 9 2004

DOYOHNY HALLINS Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

JEFEMALE:  23c. If yes, outcome of pregnancy   23d. Date of delivery   23d. Da				Please Type or Prin							gible.	
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IF FEMALE:   23b. Was decedent oregnant   1   23c. If yes, outcome of pregnancy   1   23c. If yes, outcome of death of pr		cuted nd ransit	amin	that initiated events	me Di	ا راق	(it trous	ul wa	Aone	< s	V	2 Hren
1   Yes   2   No   3   Unknown   3   Unkno	5	oe exection ar	****		consequence of	f):				71		
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1   Yes   2   No   3   Unknown   3   Unkno	5	n certil ending use a	In/Me	23h Was decedent pregnant 23c. If yes, outcome of						, 23d. Da	ate of delivery	
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25. Was case referred to medical examiner?  1		s that ined by		Part II. Other significant conditions contributing to death bu	t not resulting in t	the und	derlying cause give	n in Part I.	23e. Did t	obacco use cor	tribute to the	cause of death?
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The control of the			- 5	25 Wednesd stated to satisfact		_			1 🗆 Yes	2X No	death?	
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Description of the cause of death (Item 23a) (Type, Print)  State    City or Town, State   City or Town, State		ttendi death. stor: A r the fu	icati	2 Accident investigation	- 44			es 2 No	00(1)			
29a. Certifier (Check only age)  29b. Signature and title of certifier  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State  31. Date filled (Month, Day, Year)  29a. Certifier (Check only age)  29a. Certifier (Check only age)  29a. Certifier (Check only age)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State  31. Date filled (Month, Day, Year)  32. Registrar's Signature		tal or A rs after al Dirac ed in by	Certif	4 Homicide determined 286. Place of Injurbuilding, etc.	ry - At nome, farm . (Specify)	n, stree	et, factory, office		City or Tov	Street and Numi vn, State)	ber or Rural R	loute Number,
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State 31. Date filed (Month, Day, Year) 32. Registrar's Signature				ou. Iname and address of person who completed cause of de	ath (Item 23a) (Ty	ype, Pr	Heet	East	01	mard	4/94/	21601
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State of Maryland / Department of Health and Mental Hygiene 001 39050 1 - For State Registrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 0830 M 18 100 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HNNAPOLIS Arundel GON If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🔀 F Director 48 Yrs. 26, 1956 220-70-1765 Mar. MD Usual Residence of Decedent fited within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hyglene.
ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event. It a Madical Examinat must be notified at MD Anne Arundel Severna Park Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 109 Severn Avenue 21146 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No White Specify. ģ Specify: 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Receptionist Dental Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Heaphy Frances Ann Morgan 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jamie A. Redding/Daughter 1699 Yorktown Court, Crofton, MD 21114 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
'4 ☐ Donation 5 ☐ Other (Specify) November 23, permit, Page Department o Important: If any injury or once. Glen Haven Cemetery Glen Burnie, MD 2004 21. Signature of Funeral Service Licensee Severna Park Funeral Home Severna Park, MD 21146 . A. Hwy. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit the attending physician and Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 2 No 1 Tes 2 **Z**No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred s after dec. 1. Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical (Check only one) 29b. Signature and title of certifier )epu ause of death (Item 23a) (Type, Print) 1281 MD 31. Date filed (Monti gistrar's Signatur State Registrar

	· ·	24	1 - For State Registrar  1. Decedent's Name (First, Middle, Last)	State of Maryland			of Health of Death	7		2004	39051
10 mm	° Physic /Medi Examir	cal		TANE KRENSKY			wn, or Location		NOVEMBEI	R 17, 200 4c. County of Dea	6:05P M
, y	Funeral Director		5. Social Security Number 6. Sex 293-03-1024	7. Age (In yrs. Ia		If Under 1 Months C	Year If Under Days Hours	Min.	3. Date of Birth (Month, Day, ) ARCH 28	9. Bi	irthplace (State or Foreign Country) HIO
	ith the Maryland or 28a-f ehow	Director	10a. State 10b. County  FLORIDA SARASOTA  10e. Street and Number		Town or Lo				10g	j. Citizen of What C	10d. Inside City Limits 1  Yes 2 No Country?
920	72 hours after death with the Maryland naturel', or items 23s or 28s-f ehow dical Examinar must be notified at	by Funeral	4172 LYNDHURST  11. Marital Status  1 Never Married 2 Married  3 🖺 Widowed 4 Divorced	COURT  12. Was Decedent Ever in U.S Armed Forces? 1. ⊕Yes 2 □ No If Xes, Give Year or Dates: 943-46		Was Deceden If Yes, specify	34235 It of Hispanic Or Cuban, Mexical			14. Race - Am Black, Wh Specify: W	ite, etc.
Maryland 21215-0036	filed within 72 Hygiene. Ither than "nai Int, Ihe Wedic	e Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation o completed)  College (1-4or 5+)	(Give life.	dent's Usual C kind of work o DO NOT use i	done during mos retired)		First, Middle, Ma	OWN HO	
larylan	~ - 0 5	To Be	ROBERT DAVIS  19a. Informant's Name/Relationship (Ty)	pe, Print)	19b. Mailir	ng Address (S	F	'ANNY	SCHWARTZ	,	Zip Code)
Baltimore, M	permit. Pages 1 and 2 should be Department of Health and Menta Importants. If item 27 Is marked eny injury prother traumatic es once.		MICHAEL KRENSKY —  20a. Method of Disposition  tX Burial 2 □ Cremation 3 X R  4 □ Donation 5 □ Other (Specify)	20b. Pla	ce of Dispo netery, crer	sition (Name natory or othe	of	OAD (OAD)		20832 c. Location - City of	
Balti	permit. Departm Importa eny inju		21. Signature of Funeral Service License	de la companya de la	DÂ	NZANSK 70 ROC	ddress of Facili Y GOLDB KVILLE	ERG MI	EMORIAL ROCKVII	CHAPEL,	INC.
	Physician /Medical Examiner		23a. Rartt. Enter the disease, or complice shock, or heart failure. List only on immediate Cause (Final disease or condition resulting in death)	e cause on each line. OVARIAN_CAN Due to (or as a conseque	ICER	er the mode o	f dying, such as	cardiac or n	espiratory arrest	4	Approximate Interval Between Onset and Death  6 MONTHS
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque							
O. Box 6	death certifi e attending I id for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnand 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	eath 3	Ectopic pregr	nancy fy)			23d. Date of de Month	livery Day Year
S, D	The law requires that the ate has been signed by th page 2 should be detache	ted by Pł	Part II. Other significant conditions con-	tributing to death but not resulti	ing in the ur	nderlying caus	e given in Part I.				o the cause of death?
al Reco		Completed	05 W						24a. Was an autopsy performed 1 Yes 2X	d? prior to death?	utopsy findings available completion of cause of
Division of Vital Record	Q 5	Certification: To Be	25. Was case referred to medical examiner?  1	(Month, Day Year)	8b. Time of Injury	28c.	Other: 4 \(\to\) Nu Injury at Work? 1 \(\to\) Yes 2 \(\to\)!	rsing Home 28d	I. Describe how i		
Divi	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		4 Homicide determined  29a. Certifier 1 Certifying Physi	28e. Place of Injury · At hom building, etc. (Specify)	edge, death	occurred at th	ne time, date an	d place, and	City or Town, S	e(s) and manner as	estated
	To the Ho within 24 I To the Fu completely	Medical	(Check only 2 Medical Examinone)  29b. Signature and title of certifier	er: On the basis of examination and manner stated.	n and/or inv	estigation, in i	my opinion, dear	th occurred a	at the time, date	and place, and due  Date signed (Month	o to the cause(s)
•	12		30. Name and address of person who cor CHERYL A. AYLESWO				54378			11-18.0	7 TON,MD 20902
1	Sta Registr		31. Date filed (Month, Day, Year) NOV 2 3 200	32. Degistrar's Signatur		Span		ν. W	• DIE. 2	TOU, WHEA	10N,FID 20902

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 0 4 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** NOVEMBER 19, 2004 SALLY KLIGFIELD 9:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1711 EVELYN DRIVE ROCKVILLE MONTGOMERY If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours 1 ☐ M 2 🕅 F Yrs. 539-40-0254 90 Director 1913 NEW YORK Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits ral', or items 23a or 28e-f show Examiner must be notified at 1X Yes 2 □ No MARYLAND MONTGOMERY ROCKVILLE Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1711 EVELYN DRIVE 20852 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed withIn 72 hours after Hygiene. 1 □ Yes 2 ሺ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: WHITE þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene importent: if item 27 is marked other that any injury or other treumatic event, If and 28. 2 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be LIPKOWITZ LIPKOWITZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11911 BARGATE COURT, ROCKVILLE, MARYLAND 20852 KARIN MARTIN/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) JUDEAN MEMORIAL GDNS. 11/21/2004 OLNEY, MARYLAND 22 Name and Address of Facility
DWARD SAGEL FUNERAL DIRECTION, INC.
1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SEPTIC ARTHRITIS OF KNEE 2 WEEKS /Medical Due to (or as a consequence of): **Examiner** DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): as the burial-transit The law requires that the death certificate be executed c. ANEMIA that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 🎇 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 💢 No or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 2 1 ☐ Yes 2 X No 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours efter deat To the Funerel Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 119/2004 , mb 000 59794 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 23

2004

LE LE LUU, M.D., 1201 SEVEN LOCKS ROAD, ROCKVILLE, MARYLAND 20854

32. Registrar's Signature

2. Date of Death

ALC:	Physicia /Medic Examin	al
	Funeral	
V.	Director	

NOVEMBER 16, LILLIAN F., KAUFMAN 2004 9:14 4c. County of Death 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death BETHESDA MANOR CARE BETHESDA MONTGOMERY 8. Date of Birth (Month, Day, FEB. 9, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 1 ☐ M 2 🗓 F MARYLAND 578-20-4474 94 1910 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County rsi', or items 23a or 28a-f show Examiner must be notified at 1X Yes 2 No Director MARYLAND MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1801 E. JEFFERSON STREET #440 20852 U.S.A. death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages t and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Ite any injury go other traumatic event, tra Medical Examina once. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: WHITE þ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Rusiness/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GIFT SHOP 12 SALES 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) KIRSH ROSE LOUIS MILLER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DR. RICHARD M. KAUFMAN/SON 6224 MAZWOOD RD., ROCKVILLE, MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location · City or Town. State XBurial 2 ☐ Cremation 3 XRemoval from State KING DAVID MEM. GDNS. 11/19/2004 FALLS CHURCH, VA \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 KOCKVILLE PIKE, ROCKVILLE, MD 20852 Sonald ( +1091 23a. Pert1. Enter the disease, or complications that caused the arath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RESPIRATORY Physician /Medical Due to (or as a consequence of): **Examiner** NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit ONGESTIVE The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ LYMPHATIC LEVKEMIA 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? FIBRILLATION 24a. Was an page 2 s INSVET I CIENCY certificate MITRAL 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 ☐ Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA Nursing Home 5 Residence 6 Other (Specify) this 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification; After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No naral Diractor: / filled in by the f investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) DISTRICT OF aux MD 3166 MID COLUMBIA NOVEMBER 17, man 30. Name and address of person who completed cause of ceath (Item 23a) (Type, Print) 6224 MAZWOOD RD., ROCKVILLE, MD 20852 M.D., RICHARD M. KAUFMAN, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 23 Registrar

State of Maryland / Department of Health and Mental Hygiene 004 39054 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Anne Margaret Krupa November 2004 12:28 P<sup>™</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5 Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 221-16-4413 88 Director January 19|16 Delaware Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ?7 is marked other then "naturel", or items 23a or 28a-f show treumatic event, the Nedical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2 PNo Directo Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 570 Bellerive Drive 21401 United States 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married ☐Yes 2 No f Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Year or Dates: white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) homemaker 12 own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fil ment of Health and Mental H tent: If item 27 is marked other. Michael Kucharsey Bess Byun 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ron Krupa/ son 640 Ridgefield Ct. Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ō 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page Department of Importent: If eny injury or \* 4 □ Donation 5 □ Other (Specify) Baltimore Crematory Nov. 20, 2004 Baltimore Mt. 22. Name and Address of Facility John M: Taylor, Funeral Rome, Inc. 21. Signature of Funeral Service Licenses 147 Duke of Gloucester St. Komano-Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Septie Shock **Physician** /Medical Due to (or as a consequence of): Examiner Ochy drat Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examine The law requires that the death certificate be executed use as the burial-transil Hip Fractin resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 Physician/Medicai Fc IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Ю Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the 9☐ Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. à 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed? 2 No 1 ☐ Yes To the Hospital or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Ţ 1 ☐Inpatient 2 ☐ ER/Outpatient 3☐ DQA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending unknown - ptfounddown at death. Lyknown unknow 1 ☐ Yes 2 ☑ No 2 Accident investigation Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Jome within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) D00058297 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anne Avundel MD H. Yours 31. Date filed (Month Day, Year) . Registrar's Signature State 2 2 2004 Registrar

			1 - For State Registrer	State	of Maryla	nd / Dep <i>Ce</i>	artmen	t of H e of L	lealth and Death	Mental Hy	ygiene2 (	104	39055
			1. Decedent's Name (First, Midd	lle, Last)						2, Date of D	eath		3. Time of Death
	Physic /Medi		LETITIA BEL	LE LEA						Nov.	2.6	Year 2.0.04	2:14 pm
	Examir		4a. Facility Name (If not institution	on, give street and no	umber)		4b. City,	Town, or	Location of Dea	ith	4c. Coun	ty of Death	1
			Genesis Elde 5. Social Security Number	rCare -	The P	ines		ton	If Under 24 Hrs	8   8   8   1   1   1		albot	
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DR	laryian show	_	10a. State 10b. Count		10c. C	ity, Town or L							10d. Inside City Limits
7	tha Mi	ecto	MD T	ALBOT		EAST		0.1					1 ☐ Yes 2 ☐ No
lefilia Loa	with t	Funeral Director		DDTIVE			10f. Zip		1.601		10g. Citizen of		untry?
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-	after or Itan	Fun	1 Never Married 2 Ma	rried 1 Tyes	2 X No				ispanic Origin? ( n, Mexican, Pue	rto Rican, etc.)	BI	ack, White	
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ì	d 21213-UU36 filled within 72 hours after death with tha Maryland thygiene. uther than "natural", or Itams 23a or 28a-1 show ont, the Medicel Evant actitual by Loudilled at	Completed	15. Decede (Specify only high	nt's Education est grade completed,	)	16a. Dece (Give	edent's Usua kind of wor	al Occupa rk done d	ation during most of wo	orking	16b. Kind of	3usiness/Ir	ndustry
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3	I Hygi Hygi other	BeC	17. Father's Name (First, Middle	, Last)		10.	LOIDII			me (First, Middle			KE .
_	re, Maryland Z1Z13-5-0036 s 1 and 2 should ba filed within 72 hours alt l'Health and Mental Hygiene. item 27 is marked other than "natural", or other traumetic event, the Medicul Exprin	To B	KELCE WIREMAN						ALMA R	OBINSON			
	Z sho and h is ma		19a. Informant's Name/Relation	ship (Type, Print)		19b. Maili	ing Address	(Street a	and Number or R	ural Route Numl	ber, City or Town	ı, State, Zi	p Code)
	and and lealth m 27		ELLIS LEA, JR.	/SON			100		DRIVE		, MARYLA		
	altimore, mit. Pages 1 ar partment of Hea portant: If item y injury or othe		20a. Method of Disposition  1X Burial 2 □ Cremation	3 Removal from	1	Place of Dispo cemetery, cre	osition (Nan matory or o	ne of ther plac	θ)	Date	20c. Location	- City or T	own, State
	ITIM It. Pa rtmen rtant: njury		`4 □Donation 5 □Other (	and the state of t	MD	VETERA		-		3-2004	HURLO	K, M	ARYLAND
,	baltimore, Ma parmit. Pages 1 and 2: Department of Health at Important: If item 27 is eny injury or other trau once.		21. Signature of Funeral Service	1. Ostrows	le C.F.	CD F	ELLOWS	5, HI	is of Facility ELFENBEI RISON ST	N & NEWI EASTON	NAM FUNE MD 216	RAL I	HOME PA
	Physician	П	23a. Part1. Enter the disease, c shock, or heart failure. Lis Immediate Cause (Final disease or condition	r complications that t only one cause on	caused the dea	ith. Do not en	,	e of dying		c or respiratory	arrest,		Approximate Interval Between Onset and Death
	/Medical		resulting in death)	a. Due to	0.1	quence of):	1		<u>-</u>		<del></del>		days
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	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	for as a copse	quence of):						-	
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(	tificat ig phy as the	ledio		V									
	BOX of Bath cartif	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant		itcome of pregr		⊒Ectopic pr	eonancy				ate of deliv	,
	ne death the atte	Sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nant at time of		Other (sp		<del></del>		M	onth	Day Year
2	that the digital the detached	Ph)	Part II. Dther significant condit	ons contributing to a	eath but not re	sulting in the u	Inderhing of	auso civo	on in Part I	23e Did	tobacco uso cor	stributo to 1	the cause of death?
1	LOVISION OF VICAL RECORDS, P.O. BOX OF LOT Attending Physicien: The law requires that the death cartificate has baen signed by the attending Director: After this certificate has baen signed by the attending in by the funeral director, page 2 should be detached for use as	ted by			20dii Dai Noi 10	Solding in the C	- Indertying Ca	iuse give	m in rail( i.		Yes 2 □ No		- 1
	has by	Completed								24a. Was	an 24b.	Were auto	opsy findings available ompletion of cause of
7	The	Cor								perf 1 ☐ Yes	ormed? 2.25 No	death?	2 No
	VICION: The contribution of the contribution o	Be	25. Was case referred to medical examiner?	Hospital:				Othe		ath (Check only			
7	Phys r this aral dir	To :	1 Yes No 27. Manner of Death	28a. Date	of Injury	ER/Outpatie		Bc. Injury Work	4 Nursing F	Home 5 ☐ Res	how injury occu		(y)
	nding Path. r: After e funerr	atior	t Natural 5 ☐ Pendi 2 ☐ Accident invest	ng (Mor igation	nth, Day Year)	Injury	М		:? fes 2 □ No		. ,		
	VISIO	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 288. Place	e of Injury - At I	nome, farm, st	reet, factory	, office			Street and Num	ber or Run	al Route Number,
Č	ital or ris aft	Cer											
	To the Hospital or Attending Physicien: The within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page	edical	29a. Certifier (Check only one) 2 Medice	ng Physician: To the Examiner: On the b and mar	e best of my kn pasis of examin nner stated.	owledge, deat ation and/or in	h occurred a vestigation,	at the tim in my op	e, date and place inion, death occi	e, and due to the urred at the time,	cause(s) and m date and place,	anner as s and due to	stated. o the cause(s)
	To t To t	Σ	29b. Signature and title of certific	MA	7		29c.	. License	number	32	29d. Date signe		
			7 /	111VII				1	1657		///	29.0	T
			30. Name and address of person				,		ошем :-	D 01/01			
	Sta	te	MICHAEL D. C 31. Date filed (Month, Pay, Year		Registrar's Sign	TDLEW ]	LLD AV	E EA	STON, M	D 21601			
	Registi		MUY 3 U	2004	w B	Spe	de						

			1 - State Registrer  Ce	eartment of Health and Me		ene2004	39056
		an	1. Decedent's Name (First, Middle, Last)  ZAKT A LISHAA		Date of Death Month	Day Year	3. Time of Death
	/Medic	cal	ZAKI A LISHAA  4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	11 )	7 2004 4c. County of Dea	1905 M
	Lxaiiiii	3	SHOCK TRAUMA CENTER	BALTIMURF			
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday $218-66-8363$ 1 M $^2\square$ F $^2$ $^2$ $^2$ $^2$ $^2$ $^2$ $^2$ $^2$	Months Days Hours Min.	8. Date of Birth (Month, Day, EC • 5 •	Year)   C	thplace (State or Foreign ountry) PT
	yland now		10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show rinust be notified at	Director	MARYLAND PRINCE GEORGES MITCHELLV	ILLE			1X☐Yes 2 ☐ No
	vith th	Dire	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	ountry?
	eath v	Funeral	3508 SUNFLOWER PLACE  11. Marital Status   12. Was Decedent Ever in U.S.   13.	20721 Was Decedent of Hispanic Origin? (Spec		J.S.A. 14. Race - Ame	orican Indian
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or Items 23s or 28a-f show among injury operator traumetic event, the Medical Examinar must be notified at anone.	by	Armed Forces?  1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto R  1 ☐ Yes 2X No Specify:	Rican, etc.)	Black, Whi	
5-0	72 ho netur	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Givi	edent's Usual Occupation a kind of work done during most of working DO NOT use retired)	g 1	6b. Kind of Business	/Industry
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	Hygie other	Be Cc	17. Father's Name (First, Middle, Last)	NICIAN 18. Mother's Name (		PHOTOGRAPH aiden Sumame)	IY
Maryland	should be nd Menta r marked umetic ev	To B	AMIN LISHAA	ALLEGRA		ELGA	MIL
Jar	2 sho			ing Address (Street and Number or Rural			
	1 and Health em 27		20a. Method of Disposition 20b. Place of Disp	SUNFLOWER PLACE, M. osition (Name of Da		TLLE, MD Oc. Location - City or	
Baltimore,	Pages nent of i		1 🕅 Burial 2 □ Cremation 3 □ Removal from State cemetery, cre	omatory or other place) ON CEMETERY 11/21/			
aĦ	permit, Page Department Important: If any injury o			Name and Address of Facility DWARD SAGEL FUNERAL			ARYLAND
<u> </u>	P P P P P		" Umanael () Wallurg 10	J91 ROCKVILLE PIKE,	ROCKVII	LE, MD 20	852
П			23a. Part1. Enter the disease, or complications that caused to death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or	respiratory arres	it,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. HIP FRACTURE	WITH COMPLI	CATIONS		Oliser and Death
	Examiner		Due to (or as a consequence of):				6 WEEKS
	D ÷	ner	Sequentially list conditions, if any, leading to immediate cause. Line Uniderlying Cause (Disease or injury	7/			V WELES
	ecuter and -trans	Examiner	Cause (Disease or injury that intitated events resulting in death) Last				
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687	ificate g phys as the	0	d.		2	MINER	
Вох	death certifica e attending ph d for use as tl	an/M	IF FEMALE: 23b. Was decedent pregnant in the sect 12 months?  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 (	□Ectopic pregnancy		23d. Date of del	ivery
P.O. E	t the c by the achec	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown 5 [	Other (specify)		Month	Day Year
Ś	w requires tha been signed should be det	by	Part II. Other significant conditions contributing to death but not resulting in the t	underlying cause given in Part I.			o the cause of death?
Vital Record	The law ate has b page 2 sl	Completed			24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of 2 No
Vita	Physicien: this certificatal director,	Be	25. Was case energed to medical examinarian Hospital:	26. Place of Death (			
ō	<u>a</u> = <u>a</u>	T: To	27. Manner of D 28a. Date of Injury 28b. Time of	nt 3 DOA 4 Nursing Home	e 5 🗌 Residen 3d. Describe how	ce 6 Other (Special of the Company occurred)	cify)
ion ion	Attending ir death. ector: After by the fune	atior	1 Note 5 Pending (Month, Day Year) Injury 2 occident investigation 10 10 04 1400	M 1 Von 2 12/10	(Page)	M LADOE	ia.
Division	l or Atte after des Directo I in by th	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		3f. Location (Stre	et and Number or Ru	ıral Route Number,
	urs aft urs aft arel Di		HOME	2	NITCHE		MD
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	edical	29a. Certifier  (Check only one)  1 Certifying Physicien: To the best of my knowledge, deal of the basis of examination and/or in and manner stated.	h occurred at the time, date and place, an westigation, in my opinion, death occurred	d due to the cau d at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
1	To the within 2 To the complet	Σ	29b. Signature and little of certifier	29c. License number	290	I. Date signed (Monti	h, Day, Year)
,	5		20 Name and address of a committee of the committee of th	221975		1 17	2004
			30. Name and address of person who completed cause of death (Item 23a) (Type, Scott WEINGART 22	SOUTH GREEKE	STREE	T ADIT	more, MD
•	Sta Registr		31. Date filed (Month, Day, Year)  NOV 2 3 2004  32. Registrar's Signature	Sparker	J,L	- JAVI ()	- VIZE   / · U

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Donnell Courtney Mitchell 2004 December /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 817 North Paradise Road Aberdeen Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. May 9, 1909) 5. Social Security Number 9. Birthplace (State or Foreign Country) Mary Land 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1X M 2□ F 213-12-0790 95 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location r then "natural", or Items 23s or 28s-f show the Medical Example roughts notified at 10d. Inside City Limits Director 1 ☐ Yes 2X No MD Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 817 North Paradise Road 21001 U.S.A. Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ White 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ulth and Mental Hygiene. 27 Is marked other then "r r treumatic event, the Med Elementary/Secondary (0-12) College (1-4or 5+) Laborer 12 Farming 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Benjamin Silver Mitchell Mamie Courtney ္ရ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 Is any injury or other treu <u>once</u>. Allan Mitchell (Son) 817 North Paradise Rd., Aberdeen, Maryland 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 12/6/04 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State St. Paul's Lutheran Cem. <sup>1</sup> 4 □ Donation 5 □ Other (Specify) Aberdeen, Maryland 21. Signature of Funeral Service-Licensee Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence eavs /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): Box 68760. Completed by Physician/Medical attending p use 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. 9 Unknown 9 Unknown ģ Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 1 🗌 Yes 2 11 16 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ Ho 24a Was an page 2 s has 2 NO of Vital Yes To the Hospital or Attending Physicien: completely filled in by the funeral director, 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manger of Death 28b. Time of Injury 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death Director: / 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a to critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 10 th (Item 23a) (Type, Print) 30. Name and address of person who con lanue 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DEC 0 9 2004

			Registrar	e of Maryla	ind / Depa	artment of Hertificate of D	eaith an Death	d Mental Hy	giene (	) L <sub>i</sub>	39058
П	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of De	er 03,	Year,	3. Time of Death
	/Media	al	Ernest Eugene Mohler  4a. Facility Name (If not institution, give street as	ad number!		4b. City, Town, or t			er U3, 4c. County		12:15 A M
	Examir	ıer	Interstate 70 at Mile			Hancock		oatn .		shing t	con
	Funeral		5. Social Security Number 6. Sex	16	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hours		th v. Year)	9. Birthpla	ace (State or Foreign
	Director		217-86-1199 <sup>1</sup> ▼M <sup>2</sup> □	3	39 Yrs.	Monto Dayo	110015	Min. (Month, Da December	28, 1964		<b>Maryland</b>
	/land		10a. State 10b. County	10c. (	City, Town or Lo	cation				10	d. Inside City Limits
	Ba-f sh	tor	Maryland Allegany	Cu	mberlan	ıd					1 <b>X</b> Yes 2 □ No
	ith the	Directo	10e. Street and Number		-	10f. Zip Code			10g. Citizen of V	Vhat Countr	y?
	ath w		407 Ridgewood Avenue				1501			U.S.A	
	ter de	Funerai	Arm	Decedent Ever in ed Forces? Yes 2 X No	U.S. 13. \	Was Decedent of His f Yes, specify Cuban	panic Origin , Mexican, P	? (Specify Yes or No Juerto Rican, etc.)	- 14. Rac	e - America k, White, et	
200	urs af	þ	If Ye	s, Give r or Dates:		1 ☐ Yes 2 💢 No	Specify:		Specify	. Whi	ite
2	72 ho	Completed	15. Decedent's Education (Specify only highest grade compl	eted)	16a. Deced	lent's Usual Occupat	ion vina most of	working	16b. Kind of Bu	isiness/Indu	istry
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a	2 sho and N is ma auma		19a. Informant's Name/Relationship (Type, Prin	•				r Rural Route Numbe			
≥ ″	and lealth m 27		Thomas L. Mohler/Broth				ie, Th	urmont, Ma			
Baltimore,	it of H if ite or oth		20a. Method of Disposition 1	from State		natory or other place)	1	Date	20c. Location -		
	permit. Pages: Department of H Importent: If ite any injury or ot		* 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	Mi		et Cemeter  . Name and Address	_	/8/2004			Maryland
מ	Department of the same		P. Ryan Mcy	tellian	1			.A. Faneral			hurch Street MD, 21701
	Physician /Medical		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	that caused the dea on each line. UU (4) be to (or as a conse			such as car	diac or respiratory ar	rest,	1	Approximate nterval Between Onset and Death
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cords, r	w requires that the de been signed by the should be detached	ed by P	Part II. Other significant conditions contributing	to death but not re	sulting in the ur	nderlying cause given	in Part I.	23e. Did to	bacco use contr es 2XNo		cause of death?
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VII a	cien: ertific actor,	Be (	25. Was case referred to medical •Xaminer?					Death (Check only o	ne)		
on or	Phy this rald	tion; To	1 Natural 5 Pending	Date of Injury (Month, Day Year)	28b. Time of Injury	A 28c. Injury a Work?	ıt	28d. Describe h	ow injuge conver	ad .	at scene
DIVISION	To the Hospital or Attending within 24 hours after death.  To the Funeral Director; After completely filled in by the fune.	Certification:	3 Suicide 6 Could not be determined 28e.	3 0 4 Place of Injury - At I building, etc. (Spec	home, farm, stre sify) STYll	eet, factory, office		28f. Location (S City or Tow	treet and Numbern, State) [uff	ror Aural F	Royte Number,
	To the Hospital or At within 24 hours after o To the Funeral Direct completely filled in by	ledical (	29a. Certifier (Check only one) 1 Certifying Physician: 1 XMedical Examiner: On and	o the best of my kr the basis of examin manner stated.	nowledge, death nation and/or inv	occurred at the time restigation, in my opin	, date and pl nion, death o	ace, and due to the d	ause(s) and mar	ner as state	ed.
	To the within To the comp	Me	29b. Signature and title of certifier	.0		29c. License r			29d. Date signed		
	-		· Zahirellah				.C.M.I	E. D	ecember	03, 2	2004
	2		30. Name and address of person who completed 2ABIUCLAH	cause of death (Ite	em 23a) (Type, 1	Penn Stre	et, Ba	altimore,	Maryland	1 2120	)1
	Sta Registr		31. Date filed (Month, Day, Year) DEC 0 9 2004	32 Registrar's Sign	nature	sparks'					•

		1- For State Amend Item 2	State of Maryla 5 per Dr., G839				•	_	39059
	ysician	Decedent's Name (First, Middle, Lag     George Alber	ast)	007	imeate of	Death	2. Date of D Month	eath Day Year	3. Time of Death
	ledical aminer	4a Facility Name (If not institution, gi			4b. Gity, Town, o	r Location of Deatl		4c. County of Dea	ith 1
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Fund Direct			Sex. 7. Age (In yrs. 15€ M 2□F 66	. last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	av Year) C	rthplace (State or Foreign Jountry) Maryland
	lor	Usual Residence of Decedent	00				Feb.	13, 1930	rarytanu
larylan	<b>a</b>	10a. State 10b. County		ity, Town or Loc					10d. Inside City Limits
ZBa-1	Director	MD Dorch	ester		Link	wood			1 □ Yes 2 XNo
Meath with the Maryland ms 23e or 28a-f ehow	Dic	3640 Karen Cir	cle		10f. Zip Code	21835		10g. Citizen of What C	ountry?
death death	orner must	11. Marital Status	12. Was Decedent Ever in U	J.S. 13. W	as Decedent of H	Hispanic Origin? (S an, Mexican, Puert	pecify Yes or N	o- 14. Race - Am	
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aryland 2 should be filed and Mental Hygins marked other	To	Roy Franklin					a Holtha		
Marin and 22 sho	injury or other treumetic event, the Me.	19a. Informant's Name/Relationship  Roy Myerly	brother	12		and Number or Ru rcle, Lir		per, City or Town, State, MD 21835	Zip Code)
Tre, IN Stand of Health Filem 27	other	20a. Method of Disposition	20b.	Place of Dispos		T.	Date	20c. Location - City or	Town, State
altimo	iry or	1 ☐ Burial 2 MacCremation 3 [ 14 ☐ Donation 5 ☐ Other (Speci	_Hemoval from State		Cremato		26/04	Salisbury	, MD
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		23a. Part1. Enter the disease, or con shock, or heart failure. List only	pplications that caused the dea	th. Do not enter	r the mode of dyin	ng, such as cardiac	or respiratory a	arrest,	Approximate Interval Between
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## HE Gords, P.O. Box 68760, The law requires that the death certificate be executed the has been signed by the attending physician and	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome of pregn 1 Live birth 2 Feta 4 Pregnant at time of c	aldeath 3□E	Ectopic pregnancy Other (specify)	/		23d. Date of de Month	livery Day Year
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ds, F	2	Part II. Dittel significant conditions	contributing to death but not res	sulting in the und	derlying cause giv	en in Part I.		tobacco use contribute to Yes 2 □ No 3 □ Pi	o the cause of death?  robably 4 Unknown
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Phys of	tuneral director, page	1 ☐ Yes 2 🛣 No 27. Manner of Death	28a. Date of Injury	ER/Outpatient 28b. Time of	3 DOA Oth	4   Nursing H		dence 6 Other (Spe	cify)
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Division of or Attending after death.	Gertification:	3 Suicide 6 Could not be determined		ome, farm, stree	et, factory, office		28f. Location ( City or To	Street and Number or Ru wn, State)	ıral Route Number,
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		450	- all	E)		DAGOY		14/23/0	P
		30. Name and address of person who	completed cause of death (Item	1 23a) (Type, P	D'BRAU	BLE S	T; CI	Jey BRZDO	E, 40
Re	State gistrar	31. Date filed (Month, Day, Year) NOV 2	4 2004 Registry's Signal	ature &	Spelle				h. Day, Year)  L. J. J. J. L. J.

			1 - For State Registrar	State o	of Maryla	nd / De	partment of ertificate of	Health and M Death		ene2004	39060
	Physici /Medic		Decedent's Name (First, Middle,     ELIZABETH MASTI	ERMAN					2. Date of Death Month NOVEMBER	Day Year	3. Time of Death 4 2:35PM M
' 	Examir	er	4a. Fecility Name (If not institution, HOMESTEAD MANOR	•	,		DENT			4c. County of Dea	
	Funeral Director		5. Social Security Number  083-14-4151  Usual Residence of Decedent	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs	s. last birthda Yrs.	Months Davs		8. Date of Birth (Month, Day, MAY 7 19	year) 9. Bir Co NEW	thplace (State or Foreign yuntry) YORK
	Maryland -f show	tor	10a. State 10b. County	OLINE	10c. C	City, Town or	Location				10d. Inside City Limits 1 ☐ Yes 2 🌠 No
	death with the Maryland ms 23e or 28e-f show Frival Le rollfied at	al Director	10e. Street and Number 410 COLONIAL I	ORIVE		****	10f. Zip Code 216	29	10	g. Citizen of What Co	puntry?
9000	n 72 hours after death with the Marylan "netural", or Items 23e or 28e-f show tedical Exemples must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Marrie 3 □ Widowed 4 □ Divorced	12. Was Dec Armed F ed 1 Tes If Yes, G Year or I	cedent Ever in orces? 24 No ive Dates:	U.S. 1	3. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: WH	e, etc.
N-C171		Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	college (	) (1-4or 5+)	16a. De (Gi		ipation e during most of work ed)	sing 10	6b. Kind of Business	,
land 2	be filed tal Hygi d other event, I	To Be Co	12 17. Father's Name (First, Middle, L SEYMOUR BOEI				TEACHER	18. Mother's Nam	e (First, Middle, Ma	MUSIC aiden Surname)	
, Mary	1 and 2 should Health and Men Iem 27 is marke other traumatic		19a. Informant's Name/Relationsh SAUNDRA JEAN GRI			620	GOLDSBOR	OUGH ST.	EASTON, M	D 21601	
aitimore	t. Page rtment o rtant: If njury or		20a. Method of Disposition  1 XBurial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp  21. Signature of Funeral Service L	ecify)	Jiaio		position (Name of rematory or other place CEMETERY	12-4	-2004	OXFORD, M	ARYLAND
Da	Dermi Depa Impo any is		To HO Z.	MERC			200 S. HA	HELFENBETI RRISON ST	EASTON,	MD 21601	HOME PA
	Physician /Medical Examiner	Examiner	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. A 3 Due to  c.		quence of):	Alzk	umon			Interval Between Onset and Death
OX 00/00,	icate be physicia s the bur	edicai	IF FEMALE: 23b. Was decedent pregnant	d	atcome of pregr	nancy	3 □Ectopic pregnand	N		23d. Date of del	
5.	w requires that the death certil been signed by the attending should be detached for use a	Physician/M	in the past 12 months? 1  Yes 2 No 9  Unknown  Part II. Other significant condition	4□Preg 9□Unkn	nant at time of lown	death :	5 ☐ Other (specify)		23a Did toba	Month	Day Year
ecords,	The law requires that the tee has been signed by the hage 2 should be detache	leted by								2 🗹 No 3 🗆 Pr	obably 4 Dunknown
אוושו חפוו	an: The lar tificate has tor, page 2	e Completed	25. Was case referred to medical					26. Place of Deatl	autopsy performe	prior to death?  No 1 □ Yes	topsy findings available completion of cause of
VISION OF V	To the Hospitel or Attending Physician: The law within 24 buous after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification; To B	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could no	28a. Date (Monation on be 28e. Place	of Injury ith, Day Year)	ER/Outpat 28b. Time Injury	of 28c. Inju	iry at ork? ] Yes 2 □ No	28d. Describe how 28f. Location (Stre	et and Number or Ru	
2	tospitel or to hours afte uneral Direled in elled in	edical Cert	29a. Certifier 1 Certifying	Physicien: To the	ing, etc. (Spec	iowledge, de	ath occurred at the t	ime, date and place, opinion, death occurr	City or Town,	se(s) and manner as	stated.
	To the le within 2.  To the le complete	Med	one) 29b. Signature and title of certifier	and man	ner stated.		29c. Licen	se number	290	. Date signed (Month	
			30. Name and address of person w		se of death (Ite	m 23a) (Typ	e, Print)		15 bu	109	91635
	Sta Registr	te	31. Date filed (Month Day, Year)	2004	Registrar's Sign	nature	enter An				3.5

	1 - For State Registrar			viaryland /		rtment of F tificate of			Reg. No.	- T	9001
		me (First, Middle, La	st)					2. Date of De. Month	ath Day	Year	3. Time of Death
Physician /Medical		A. Montg	omery					Novemb		2004	1:04 PM
Examiner	4a. Fecility Name	(If not institution, giv				* .	r Location of Deat	ר	4c. County	of Death	
per .		ton Advent				Takoma				tgome	
Funeral Director	5. Social Security 579-20-8		6ex M 2□F	Age (In yrs. last b	Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da May 30	v. Year)	9 Birthp Coun Wash	lace (State or Foreigr try) ington, DC
p ,	Usual Residence	of Decedent		10c. City, To	um or Loc	ation				1	0d. Inside City Limits
aryla shov										1,	1 ☐ Yes 2 ♣ No
with the Ma to 28a-f a be notified	Maryland	1	mery	Silve	er sp	10f. Zip Code			10g. Citizen of	M/h = 1 Cours	40.0
Mith t	10e. Street and N	nhall Way				20904				JSA	uy:
eath	11. Marital Status		12. Was Decede	ent Ever in U.S.	13. W	1	lispanic Origin? (S	pecify Yes or No		ce - Americ	an Indian
s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. If health and Mental Hygiene. It is marked other than "naturel", or Items 23a or 28a-f show other traumatic event, the Mexical Executational be notified at To Be Completed by Funeral Director	3 ☐ Widowed	rried 2. Married 4 □ Divorced	Armed Force	es?	lf 1	Yes, specify Cuba	Specify:	o Rican, etc.)	Bla	ck. White, yWhite	etc.
- 100	(Sp	15. Decedent's Electify only highest gra	ade completed)		Sa. Decedi (Give h life. D	ent's Usual Occup and of work done O NOT use retired	ation during most of woi d)	rking	16b. Kind of B	lusiness/Ind	dustry
within ene. than " the Mes	Elementary/Se	condary (0-12)	Coilege (1-4 4	or 5+)		anical E			U.S. Go	overni	nent
Hygie other ent, III	17. Father's Nam	e (First, Middle, Last	)					ne (First, Middle,			
Mental Me		A. Montgo	omerv				Louise	Goldsmi	ith -		
d 2 should be flike th and Mental Hy ?? is marked oth traumatic event		Name/Relationship (		19	9b. Mailing	Address (Street	and Number or Ru			, State, Zip	Code)
nd 2. lith a lith a 27 is r trat	Dorothy	Montgome	ru/Wife	8	306 W	inhall W	May, Silv	er Strir	or. MD 2	20904	
Department of Hea Department of Hea Important: If item any injury or othe	20a. Method of D	isposition	· ·	20b. Place	of Dispos	ition (Name of		Date	20c. Location		wn, State
ent o		2 □ Cremation 3 □ n 5 □ Other (Specif			te of Cemet	atory or other place Heaven	20	mber 23 04	ilvar 9	String	, Maryland
permit. Pages 1 and 2 should be filed withir Department of Health and Mantal Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Monce.		Funeral Service Lice			22 F r	Name and Addre	ss of Facility Collins Sity blv	Funeral	L Home ]	Inc	MD 20901
	23a. Parti. En	r the disease, or comeant failure. List only	plica ions that cau	sed the death. De	o not ente	r the mode of dyir	ng, such as cardiad	or respiratory a	rrest,		Approximate Interval Between
Physician /Medical	Immediate Caus disease or cond resulting in deat	e (Final ition	a. 1	as consquence	tu e of):	in P	neur	nomi	O1	5	Onset and Death
Examiner j	Sequentially list if any, leading to cause. Enter Un Cause (Ulsease that initiated eve	conditions,	b. Due to (or	as a consequenc	Columbia e of):	ellro	weul	ars	Rulit	1 7	3 Jays
icate be executed physicien and s the burial-transit clical Examiner	resulting in death	or injury nts n) Last	c. Due to (or	as a consequenc	e of):						
tificate be ng physicie as the bur			. 0								
The law requires that the death certifica to has been signed by the attending proage 2 should be detached for use as the completed by Physiclan/Med	IF FEMALE: 23b. Was deced in the past 1  Yes 9  Unknow	12 months? 2 □ No		n 2 ⊡ Fetel dea nt at time of death		Ectopic pregnancy Other (specify) _	/			ite of delive onth	ny Day Year
uires that the decrease in signed by the a lid be detached to detach	T art III. Othlor Sig	nificant conditions	contributing to deal	th but not resulting	in the un	derlying cause giv	en in Part I.		obacco use coni Yes 2□No		e cause of death? ably 4 Dunknown
The law require cate has been single 2 should be Completed		grover	ry a	Litery	10	wear	el		osy ormed?	prior to cor death?	osy findings available
n: The law requires the ficate has been signe or, page 2 should be completed by		ferred to medical					Of Place of Dog			1 🗌 Yes	<b>2</b> ₩0
Physician r this certifical director	examiner?		Hospital:	estiont 2 PER	Outpationt	3□ DOA Oth	or.	ith <i>(Check only o</i> lome 5 ☐ Resid		- /Cassif	-1
ng Phyeir ter this c neral dire	1   Yes 2   No					28c. Injur Wor	1100)212		how injury occur		7
atte	2 ☐ Acciden	livesigatio		f Injury - At home,	farm, stre	et, factory, office		28f. Location (S City or Tox	Street and Numb vn, State)	ber or Rura	l Route Number.
tal or Attendir's after death.  al Director: After by the furth of the	2 Acciden 3 Suicide 4 Homicid	6 Could not b	200. Place 0	, etc. (Specify)							
ie Hospital or Attending P 24 hours atter death. Ne Funeral Director: After to Netely filled in by the funeral edical Certification;	2 Acciden 3 Suicide 4 Homicid  29a. Certifier (Check only one)	6 Could not be determined	200. Place 0	est of my knowled	lge, death and/or inv	occurred at the tirestigation, in my o	me, date and place pinion, death occu	, and due to the	cause(s) and madate and place,	anner as st and due to	ated.
To the Hospital or Attendit within 24 hours after death. To the Funeral Director: All completely filled in by the further Medical Certificatic	29a. Certifier (Check only one)	6 Could not be determined	building hysician: To the bas	est of my knowled	ige, death and/or inv	occurred at the tirestigation, in my c	pinion, death occu	o, and due to the	cause(s) and madate and place,	and due to	ated. the cause(s)
To the Hospi within 24 hour To the Funel completely fill	29a. Certifier (Check only one)	6 Could not be determined	building hysician: To the bas	est of my knowled	ige, death and/or inv	estigation, in my o	pinion, death occu	o, and due to the	date and place,	and due to	ated. the cause(s)
To the Hospital or Attendir within 24 hours after death. To the Funeral Director: After completely filled in by the funeral management of the function of the	29a. Certifier (Check only one)	6 Could not be determined 2 Medicel Exemple 1 Medicel Exemple 1 Medicel Exemple 2 Me	building hysician: To the bas	est of my knowled	and/or inv	estigation, in my o	pinion, death occu	o, and due to the	date and place,	and due to	ated. the cause(s)

Registrar

			1 - For State Registrar AVEND#12per IN	F11/29/04	Marylar	nd / Depa	artme		ealth a	and Me	ental Hy	giena Reg. No	ริกก		390	162
	Physici	an	1, Decedent's Name (First, Middle, La	st)							<ol><li>Date of De Month</li></ol>	ath Da	y	Yeer	3. Time o	
	/Medic Examin	al	Irwin L. Neveu, 4a. Facility Name (If not institution, giv		ber)		4b. Cit	, Town, or	Location o		Novemb		. County o	004 f Death	6:05	рм
			Holy Cross Hospi	tal			S	ilver	Spr	ine		Mo	ontgo	nery	<u> </u>	
	Funeral		5. Social Šecurity Number 6. S	ex ☑M 2☐F	7. Age (In yrs.	last birthday) Yrs.	If Und Month		If Under a	Min.	8. Date of Bir (Month, Da	th ay, Yea <i>r)</i>		9. Birthr	place (State ntry)	or Foreign
	Director		435-16-4928 Usual Residence of Decedent	A	86	115.					May 16	,191	L8	Loui	siana	
	land fr		10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation		-						IOd. Inside C	City Limits
	Marylan f show	ξ	Maryland Montgo	mern		Silver	Snri	na							1 🗌 Yes	2 <del>∏</del> No
	within 72 hours after death with the Maryland ane. than "natural", or Items 23e or 28e-f show the Madical Evantinar must be indiffied at	Director	10e. Street and Number	mery		TIVEL		ip Code				10g. Ci	tizen of W	nat Cour	ntry?	
	3a o	ī [	2505 Glenallen Av	anua #	101			-	0906				USA			
	death	ner	11. Marital Status	12. Was Dece	dent Ever in U	J.S. 13.	Was Dec			gin? (Spec	cify Yes or No Rican, etc.)	)-	14. Race	- Americ	can Indian,	
9	or Ite	Ē	1 ☐ Never Married 2 🔀 Married	Yes -	<del>2 ∑No</del>			2 <b>⊠</b> No			ilcari, etc.)					
21215-0036	iral',	Completed by Funeral	3 ☐ Widowed 4 ☐ Divorced	Year or Da	ites: WW-I	I		222110	ороспу.				эрвспу.	MIX	ed Rac	e
5-	72 h	ete	15. Decedent's E (Specify only highest gra	ducation ade completed)		16a. Dece (Give	dent's Us	ual Occupa	ation furing most ')	t of workin	g	16b. K	(ind of Bus	iness/In	dustry	
121	han han	ш	Elementary/Secondary (0-12)	College (1-	-4or 5+)	l _			,							
	lled v lygie her t		12 17. Father's Name (First, Middle, Last	1		Carp	ente	r	18 Mothe	ar's Nama	(First, Middle		dwor			
and	od ol	Be											, comamo	,		
Ē	hould d Me mark matic	은	Fortunet Neveu  19a. Informant's Name/Relationship (			19b. Maili	na Addre	ss (Street a			Journe Route Numb		or Town S	tate. Zir	Code)	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla, if Health and Mental Hygiene. If the Maryla Item 27 is marked other than "natural", or Items 23e or 28e-1 show other traumatic event, the Medical Evantural must be multibled at				. c -											2006
	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra		Marie R. Neveu 20a. Method of Disposition	W.	ife 20b. 1	Place of Dispo	osition (A	ane of	aver	nue #	101 Si	20c. L	ocation - C	ity or To	MD 20 own, State	J906
Baltimore,	ages and of		1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 📆 Other (Special	Removal from S	State Ga	Place of Disponentery, creater of	Heav	en	θ)							
	artme ortan Injur		21. Signatu e of Fineral Service Lice		пептц	2	2. Name	tery and Addres	s of Facilit	v	2,2004					
Ba	Dep Imp	15	1/26.15	Kam	16	Fr	anci	s J.	Colli	ins F	uneral ,W.,Si	Hon	ie, Ii	ic.	MD 200	201
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or come shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	aAspin	aused the dear ach line cation or as a consec estive	th. Do not en  Pneumo quence of):	nia	ode of dyin	g, such as	cardiac or	respiratory a	rrest,		-	Approxima Interval Be Onset and	te tween
8760,	tificate be executed g physician and as the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Chron	or as a consecutive or as a consecutive or as a consecutive or as a consecutive or ary.	dural quence of):	Hema	toma								
P.O. Box 68	death cer e attendir d for use	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown		irth 2 ☐ Feta ant at time of c	al death 3[	⊒Ectopic ⊒ Other (	pregnancy specify)					23d. Date Mont		-	Year
	requires that the een signed by th hould be detache	y P	Part II. Other significant conditions	contributing to de	ath but not res	sulting in the u	ınderlying	cause give	en in Part I.		23e. Did 1	tobacco	use contrib	oute to t	he cause of	death?
Records,	puires n sign	Q D	Renal Insuffi	ciency							1 🗆	Yes 2	□No 3	□ Prot	ably 4 🗷	Unknown
00	w require been signature should b	jete	Diabetes Type	TT							24a. Was		24b. W	ere auto	psy findings	available
Re	The law rate has be page 2 sh	ЩC		- L								ormed?	de	ath?	mpletion of a 2□ No	cause of
Vital			25. Was case referred to medical						26 Place	of Death	1 ☐ Yes (Check only o		11	7 1 62	2 L NO	
>		To Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 € II	npatient 2	ER/Outpatie	nt 3 🗆 I	Othe			ne 5∐Resi		6 DOther	(Specif	v)	
0	g Physer this eral di		27. Manner of Death	28a. Date o	of Injury h, Day Year)	28b. Time o	of	28c, Injury	/ at		8d. Describe				,,	
ion	ath. r: Aft	atio	1 Natural 5 Pending 2 Accident investigation		n, Day rear	Injury	М		Yes 2 □ I	No						
Division of	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	286. Place	of Injury - At h ng, etc. <i>(Speci</i>	nome, farm, st	reet, fact	ory, office		2	8f. Location ( City or To	Street ar wn, State	nd Number e)	or Rura	I Route Nun	nber,
	ne Hospi 24 hou ne Funer pletely fill	Medicai	29a. Certifier 1 Certifying Pi (Check only 2 Medicel Exa		sis of examina											s)
	withii To th	Ň	29b. Signature and title of certifier	. ^ -	υ Δ		2	9c. License	e number			29d. Da	ite signed	(Month,	Day, Year)	
	7		12/55	month	m ( .			D 592	84			No	vembe	r 1:	8,2004	
	1		30. Name and address of person who Shahid Shamim,		e of death (Ite 299 Lam		Print)			Spr	ing, M				~ <del>, ~</del>	
	Sta Begist	ate rar	31. Date filed (Month, Day, Year)	32. B	egistrar's Sign	ature 4	1	no Va								

			1 - For State of Registrar		partment of Health and N ertificate of Death	1ental Hygie	20114	39063
			Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
	Physici /Medic		PATRICK EDW	IARD	O'MALLEY		Day Year 30 2004	4:35AM
	Examir		4a. Facility Name (If not institution, give street and numb	er)  Rel 1:	4b. City, Town, or Location of Death		4c. County of Death	acd
	Funeral		5. Social Security Number 6. Sex 7	Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthp	place (State or Foreign
	Director		Usual Residence of Decedent	62 Yrs.		3/24/1		ryland
	show	_	10a. State 10b. County	10c. City, Town or			1	0d. Inside City Limits 1 ☐ Yes 2 🛣 No
	the Ma 28a-f	Director	MD. Harford  10e. Street and Number		Fallston  10f. Zip Code	100	Citizen of What Coun	
	3a or	Ö	3215 Suffolk Lane		21047		United S	*
	death	Funeral		ent Ever in U.S. 1	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		14. Race - Americ	an Indian,
98	burs after death with the Man rai', or Items 23a or 28a-1 sh Examinar must be notified	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 If Yes, Give Year or Date	□No T	1 ☐ Yes 2 No Specify:	rican, etc.	Specify:	hite
21215-0036	on 2 should be filed within 72 hours after death with the Maryland alth and Mental Hygiene.  To 1s marked other than "natural", or items 23a or 28a-f show in 27 is marked other than "natural", or items 23a or 28a-f show in traumatic event, the Medical Examinat must be notified at	ted t	15. Decedent's Education (Specify only highest grade completed)	16a. De	cedent's Usual Occupation ve kind of work done during most of work	166	. Kind of Business/Inc	
121	I within 72 he iene. Then "natu	Completed	Elementary/Secondary (0-12) College (1-4	life	Salesman		mmomaial	Toogramm
5	il Hygie other i	Be Co	12 1  17. Father's Name (First, Middle, Last)			e (First, Middle, Maid		Leasing
Maryland	2 should be filed and Mental Hygi Is marked other reumatic event,	To B	Edward Charles					omyer
<u></u>	12 she nand land		19a. Informant's Name/Relationship (Type, Print)		ailing Address (Street and Number or Run			
	s 1 and 2 should f Health and Men item 27 is marke other treumatic		Kathleen E. Kilby/Sis	20b. Place of Dis	3 Grafton Shop I		rest Hil Location - City or To	
Š	90=2		1 MBurial 2 □ Cremation 3 □ Removal from St '4 □ Donation 5 □ Other (Specify)	ate cemetery, c	rematory or other place)			ille Md.
Saltimore	permit. Pag Department Importent: I any injury o		21. Signature of Euneral Service Licensee	Dan I e Cos			ille, Ma	
α.			1. Alacker Te	was -	E.G. Kurtz & S	son Fune	ral Home	
			23a. Part1. Enter the disease, or complications that can shock, or heart failure. List only one cause on ear	used the death. Do not o	enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	r as a consequence of):	adorocur cinomo	_	-	3 months
	Examiner			as a consequence on.				
nd e	/ pe lisi	iner		r as a consequence of):				
P -	be executed ician and burial-transit	Examiner	that initiated events c.	r as a consequence of):				
8760	cate be executed only sician and the burial-transit	dical	d.					
· · · · · ·	eath certifica attending ph	/Med	IF FEMALE: 23c If yes outcome	ome of pregnancy				
Box	death o	Physician/Me	in the past 12 months?  1 Vac 3 Na 4 Pregnar	h 2 Fetal death nt at time of death	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive Month	ery Day Year
2) 0	that the ded by the detached	physi	9 ☐ Unknown 9☐ Unknow					
7	sa us a	by	Part II. Other significant conditions contributing to dea	th but not resulting in the	o underlying cause given in Part I.		co use contribute to th 2 ☐ No 3 ☐ Probi	ne cause of death? ably 4 □Unknown
Mal	w requir been si should	letec	CAD	<del>-( · · · · · ) · ·</del>	and the same of th	24a. Was an		psy findings available
S P	The larate has	Completed				autopsy performed 1 ☐ Yes 2 🔀	? prior to con death?	npletion of cause of
	Physician: The this certificate ral director, page	Be	25. Was case referred to medical examiner?			h (Check only one)		
75	Phys this	. To	1 Yes No Hospital: 1 In Inc. 27. Manner of Death 28a. Date of			me 5 Residence 28d. Describe how in	6 Other (Specify	)
ع لے،	ding h. After fune	tlon	Natural 5 Pending (Month,	Day Year) Injur	y Work? M 1 ☐ Yes 2 ☐ No	20d. Describe flow ii	ijary occurred	
CATI	or Attendi after death. Director: A 3 in by the fu	Certification:	3 Suicide 6 Could not be 28e. Place o	f Injury - At home, farm, a, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St	and Number or Rural	l Route Number,
0 0	Hospitel or 24 hours afte Funeral Dire tely filled in t		20. Cartifice (Contifuing Physicians Table b	ant of any limited and decorate				
	To the Hospitel within 24 hours a To the Funeral if	edical	29a. Certifier (Check only one)  1 ★ Certifying Physician: To the base and manner.	is of examination and/or	eath occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the cause red at the time, date	e(s) and manner as stand due to	ated. the cause(s)
	To the To the Complet	Me	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month, L	Jay, Year)
	7		Patyon M		D29227	10	(30(14	
	2		30. Name and address of person who completed cause PATRILIA DUBYSSK	of death (Item 23a) (Typ	W. Mar Phail R.	& Bel Air	MD 21	314
1	Sta		31. Date filed (Month, Day, Year) 32. Rec	gistrar's Signature	1			1
	Registi	rar	DEC 0 9 2004	War Co	sparks			

State of Maryland / Department of Health and Mental Hygiene 004 1 - For State Registrar 39164 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** OCTOBER 24, 2004 NELL H. OGDEN 2:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 7101 BAY FRONT DRIVE, APT 610 ANNAPOLTS ANNE ARUNDEL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 ☐ M 2 👿 F 73 Director JUNE 11, 213-30-6366 1931 MARYLAND Usual Residence of Decedent 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits or 28e-f show other traumatic event, the Madical Examiner must be notified at Director 1 ☐ Yes 2 🙀 No MD ANNE ARUNDEL ANNAPOLIS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7101 BAY FRONT DRIVE, APT 610 or Items 23a 21403 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after □Yes 2 No 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify: WHITE ò 3 Widowed 4 Divorced naturel', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 7 and Mental Hygiene.
7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 5+ 12 TEACHER **EDUCATION** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CHARLIE HUGHES POLLY TAYLOR ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n eny Injury or other traun once. WILLIAM J. OGDEN/HUSBAND 7101 BAY FRONT DR., APT 610, ANNAPOLIS, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State BROADCREEK CEMETERY \* 4 ☐ Donation 5 ☐ Other (Specify) 10/28/2004 STEVENSVILLE, MD 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Approximate Interval Between Onset and Death Breast Immediate Cause (Final disease or condition resulting in death) Cancer **Physician** yeave /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): certificate be executed burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 esidence 6 Other (Specify) 2 1 ☐ Yes 2 🙀 No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funerel L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a, Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Strant elonick, M.O. 900 Bectyate Rd. Annapolis, Md. 21401 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

		1 - For State RegistraMFND TTRM #  1. Decedent's Name (First, Middle, Last	State of Maryla  24a PER PHY (					ind M	2. Date of Deat	ng. No.	004	3 9 0 6 S
Physic /Med Exami	ical	ARLAIN POTTS  4e. Facility Name (If not institution, give	street and number)		4b City	Town or	Location of	f Death	Month 11	20 20	Year 2004 County of Death	1:38 P
Funeral	ilei	33076 W. POST OFFI 5. Social Security Number 6. Se	CE ROAD  7. Age (In yrs	. last birthday)	PR If Under	INCI 1 Year	ESS AN	INE	8. Date of Birth (Month, Day,		SOM	ERSET  place (State or Fore
Director		Usual Residence of Decedent	M 2□F 7		Months	Days	Hours	Min.	09-26-1	932	SILO	intry) AM,MARYL
r the Marylar r 28a-t show	Director	10a. State         10b. County           MD         SOMERS           10e. Street and Number		RINCESS					10	Og. Citize	en of What Cou	10d. Inside City Lim 1 ☐ Yes 2 ☐ I
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within 72 ene. then "na	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation	16a. Decec (Give life. I	dent's Usua kind of wor DO NOT us ELECT	k done d e retired	furing most )	of workin	g 1		of Business/Ir	•
ould be filed Mental Hygi arked other	To Be Co	17. Father's Name (First, Middle, Last) ELLIS POTTS			LLLOI	KIOI	18. Mother		(First, Middle, M			ICAL
Pages 1 and 2 should nent of Health and Men int: If Item 27 Is marke iry or other traumatic		19a. Informant's Name/Relationship (TyRANTZ PURCELL - GR 20a. Method of Disposition  ¡X□ Burial 2 □ Cremation 3 □ F  '4 □ Donation 5 □ Other (Specify)	ANDSON 20b. emoval from State		O ARD sition (Nam natory or ot	EN S	STATIO	N RD	ate 2	ESS loc. Loca	ANNE, Nation - City or T	4D. 21853
permit. Pag Department Important: J eny injury o		21. Si nature d'Euneral Service Licens		22	. Name and	Addres	s of Facility	BOU	NDS FUN	ERAL	HOME,	
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	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci	<i>Ty)</i>					City or Town,	State)		il Route Number,
To the Hospital or within 24 hours after To the Funeral Direction completely filled in	Medical	29a. Certifier (Check only one)  29b. Signature and title of certifier	ician: To the best of my knier: On the basis of examination and manner stated.	owledge, death ation and/or inv	estigation, i	t the time in my op License	inion, death	place, an	at the time, dat	e and pla	ace, and due to	the cause(s)
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IVA	ate	30. Name and address of person who co	32. Regultrar's Sign	wer 5	÷.	So	lish	un	M	9		

		•	For State	State of Maryland		artment of H				04	39066
	Physici /Medic		Registrar  1. Decedent's Name (First, Middle, Last, LAWRENCE	VICTOR		POE	Death	2. Date of Dea Month Novembe	Day	2004	3. Time of Death 2:30P. M
	Examin		4a. Facility Name (If not institution, give Laurel Regional			4b. City, Town, o Laurel	r Location of Deat	h		inty of Death	orge's
	Funeral Director		5. Social Security Number 6. Se 579–12–7120 15	7. Age ( <i>In yrs.</i> last		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day Sept. 1	B, 1920	9. Birth Cou Mary	place (State or Foreign ntry) rland
	Maryland I show	tor	10a. State 10b. County Maryland Prince (		Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 🌠 No
	th with the 23s or 28s ist be noti	al Director	10e. Street and Number 4411 Greenwood Roa	ad		10f. Zip Code 20	705		_	of What Cou	
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene.  Department: If tiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Modical Examinar must be notified at once.	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 🛣 Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 1942–19		Vas Decedent of H f Yes, specify Cub I ☐ Yes 2 1 No	dispanic Origin? (S an, Mexican, Puer Specify:	specify Yes or No- to Rican, etc.)		Race - Ameri Black, White, pcify: W	
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Maryla	d 2 should th and Men 7 is marks traumatic	2	19a. Informant's Name/Relationship (7) Maurice P. Alsop	rpe, Print) -Executor	19b. Mailin 4309	g Address (Street Vergie A	and Number or Re Venue Be.		r, City or Tox Mary	wn, State, Zij Land 2	20705
Baltimore, I	Pages 1 and nent of Healt of Healt its If itsm 2 Iry or other		20a. Method of Disposition  1X Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)	cen	netery, cren	sition (Name of natory or other plac ge Memor	ial Park			on - City or To	own, State
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Registrar

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ary	shou ind M imar umat	۲	19a. Informant's Name/Relationship (			19b. Mailir	ng Address	(Street a	and Numbe	r or Rura	l Route Numbe	r, City or	Town, State,	Zip Code)
	and 2 ealth a n 27 is		Judy Monie (Dau	ighter)						rede	rick, M			
Ĕ	of He		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □	Removal from S	Statter !	Place of Dispo cemetery, crei			1-	eceml	ber 2,	20c. Lo	cation - City or	r Town, State
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Ba	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 Ia marke any injury or other traumatic. Once.		21. Signature of Funeral Service Licer		- 010		2. Name an				J.L. Da			1 Home 1and 21783
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	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifying Pt (Check only one) 2 Medicat Exam	miner: On the ba	best of my knows as so of examination of examinations and examinations.	owledge, deat ation and/or in	h occurred vestigation	at the tim , in my of	ie, date an pinion, dea	d place, a th occurre	and due to the dead at the time, of	ause(s) date and	and manner a place, and du	s stated. e to the cause(s)
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	1		30. Name and address of person who	4		m 23a) (Type,	Print)	-	30.0	16.10	ex m	) )	171/-	
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/Medical	Mark Thoma 4e Fecility Neme (If not institu	as Riley ution, give street end number)			4b. City, Town, or Lo		4c. County	
Examiner	304 Academy S				Hurlock			hester
Funeral	5. Social Security Number	6. Sex, 7. Ag	je (In yrs. lest birth	(ay) If Under 1 Yea	r If Under 24 Hrs.	8. Date of Birth (Month, Dey,	Voorl	Birthplace (State or Ford Country)
Director	213-70-8218	1 <b>5</b> €M 2□ F	45 Yr.	Months Day		Nov. 26		Maryland
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ashow and		orchester	Too. Oily, Town o		11-			1 X Yes 2□
be filed within 72 hours after death with the Maryland tall Hygiene.  d other than "natural", or flems 23s or 28s-f show event, the Medical Examiner must be notified at Be Completed by Funeral Director	10e. Street end Number	Dichester	1	10f. Zip Code	lock	10	Og. Citizen of W	/het Country?
With Day	304 Academy	7 St.			21643		USA	
me 23	11. Marital Status	12. Was Decedent	Ever in U,S.	13. Was Decedent of	Hispanic Origin? (Spe	cify Yes or No-	14. Race	- American Indian,
or ite	1 Never Merried 2 N		No	,		Rican, etc.)		k, White, etc.
by Fair, o	3 ☐ Widowed 4 🕱 Divor	rced If Yes, Give Year or Dates:		1□ Yes 2,7X No	o Specify:		Specify:	white
ygiene.  wr than "natura  nt, the Medical S  Completed	15. Dece (Specify only his	dent's Education ghest grede completed)	16e. D	ecedent's Usual Occi	upation e during most of working red)	ng	16b. Kind of Bu	siness/Industry
than the Market	Elementary/Secondary (0-1		5+)	fe. DO NOT use retii truck dr.			<b></b>	and a last and
d other than event, the M Be Comp	12 17. Father's Neme (First, Midd	die Last)		Cruck ur.	18. Mother's Name	/First Middle A		portation
ris marked other than traumatic event, the M	Bobby T. Ri					4cCarter		5)
marker matic	19a. Informant's Name/Relati		19b. k	Mailing Address (Stree	et and Number or Rura			Stete. Zip Code)
Health ar	Russell Rile				3, Hurlock		643	31313, 24 3333,
other	20a. Method of Disposition	•	20h Place of D	isposition (Name of		Date 2	20c. Location - 6	City or Town, State
y or o	1 ☑ Burial +2 ☑ Crematic 4 ☐ Donation 5 ☐ Other	or 3 Removal from State	Dörc	cremetory or other plane. The Ster Mei	m. Park 1.	1/27/04 <del>/24/04</del>		ldge, MD ury, MD
Department of important: If it any injury or o once.	21. Signature Funeral Serv		Darisbo	22. Name and Add		mas Fun		
E E S	1 Lhings	0 000		700 Locust	t St., Camb			
	23a. Part1 Enter the disease	e, or complications that caused List only one cause on each li	the deeth. Do not	enter the mode of dy	ying, such as cardiac o	r respiratory arre	est,	Approximate Interval Between
ysician	Shock, of frealt failule.	List only one cause on eech li	1		(			Onset and Death
edical	Immediate Cause (Final disease or condition		LATO	Line	Tursher	- No	worl	
aminer	resulting in death)	α.	Due to (or as a cor	nsequence of):				
ial-transit		b						
unial-transit	Sequentially list conditions, if any, leading to immediate		Due to (or as a cor	nsequence of):				
2 =	cause. Enter Underlying Cause (Diseese or injury that initieted events	c	Due to /or so a so					
or by the attending physic letached for use as the best letached for the best letached fo	resulting in death) Last		Due to (or as a cor	isequence oi).				ŀ
sattanding physicis of for usa as the bu IclaryMedical		d						<u> </u>
by the att stached fo physici	Part II. Other algnificant cond	ditions contributing to death b	ut not resulting in th	ne underlying ceuse g	jiven in Part I.	23b. Did tol	bacco use con	tribute to the cause of dea
d by t letach						1 □ Ye	s 20 No	3 ☐ Probably 4 ☐ Unkn
signed to the details of the details						- III		24b. Were autopsy finding
page 2 should l						24a. Was ar perform	ned?	available prior to completion of cause
page 2 s						A.e.		of death?
certificate rector, pag						Ye		Yes 2□ No
s certific director, <b>[o Be</b>	25. Was case referred to med examiner?	Hospital:			26. Place of Death	P.S 197 - 197 - 19	-	At agar
三流 一	1 XYes 2 No 27. Menner of Death	1 LI Inpatie		atient 3LJ DOA	4LJ Nursing Hon	ne 5∐ Reside !8d. Describe ho		r <i>(Specify)</i> At SCET od
al Director: After t led in by tha funera Certification:	1 □Natural 5 □ Per	nding estigation 28e. Date of Inju	y Year) Inju	ry W	ork? ⊒Yes 2.21No	Such	ect	Artrolf
Director: Ald in by the fu	Suicide 6 □ Cou	uld not be 28e. Hace of Inj	ury - At home, farm	, street, factory, office	9 2	8f. Location (Str City or Town	eet and Numbe	r or Rurel Route Number,
s = ==	4 Homicide	building, et	c. (Specify)	ME	3	City or Town	State)	ST 21643
		fying Physician: To the best	of my knowledge, d	eeth occurred at the				
hours aft iners! Dir ly filled in cal Cer	CORP ONLY DETRICAL	cal Examiner: On the basis of and manner ste	eted.					
in 24 hours afti he Funeral Dir pletaly filled in edical Cer	(Check only 2 Medic			29c. Licer	nse number		•	(Month, Day, Yeer)
To the Funeral Discompletaly filled in		Tiffer -						
completaly filled in	one)	teno		0.0	.M.E.	N	Novembe:	22, 2004
Hospi 14 hou Funer taly fill	one)	teno	1 0	pe, Print)				
To the Hospital or within 24 hours afte To the Funeral Dir completaly filled in Medical Cert	29b. Signature and title of cert  30. Name and address of pers	son who completed ceuse of d	N	pe, Print)	.M.E. treet, Bal			
To the Hospital or Attending Physician: The law requires the within 24 hours after death.  To the Funeral Director: After this certificate has been signed completaly filled in by the funeral director, page 2 should be deadless.  Medical Certification: To Be Completed by	29b. Signature and title of cert  30. Name and address of pers  31. Date filed (Month, Day, Ye	son who completed ceuse of d	1 0	pe, Print) 111 Penn S				

		1- State of Maryland / Department of Health and Me Registrar  Certificate of Death	•	ne 2001 20070
Physici /Medic	al	Mary Katherine Sullivan	2. Date of Death Month	Day - 2004 1250M
Examin	ier	Months Days Hours Min	8. Date of Birth (Month, Day, Ye	4c. County of Death  TA 1 0 0+  ar)  9. Birthplace (State or Foreign Country)
Director		220-01-6073	Aug. 14,	1921   Maryland   10d. Inside City Limits
with the Maryland as or 28a-f show	Director	Maryland Talbot Easton  10e. Street and Number 10f. Zip Code	10g.	1 1 des 2 □ No Citizen of What Country?
deeth deeth	Funeral	201 Federal Street  21601  11. Marital Status  1 Never Married 2 Married  21 Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  21 Married 2 Married  21 Married 2 Married  21 Married 12 Married  12 Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto R		14. Race - American Indian, Black, White, etc.
Mark Constitution of the Millin 72 hours efter than "natural", or liter to Medical Examina	Completed by	3 (Midowed 4 □ Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	g 16b.	Specify: Black Kind of Business/Industry
Ind 212	Be Comp	Elementary/Secondary (0·12) College (1-4or 5+)  8  Minister  17. Father's Name (First, Middle, Last)  18. Mother's Name (	Bet	thel A M E Church
Varyland 2 ore, Maryland 2 ore, Maryland 2 or 1 and 2 should be filed the arrive marked other other treumatic event, 1	ToE	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural)	inters Route Number, Cit	y or Town, State, Zip Code)
MULTINOLE, N. Pages 1 and nent of Health ont. If Health ont. If Health uty or other tury or other turns or othe		Peggy Ann Wilkins / Daughter  161 B Mount Pelier Str  20a. Method of Disposition  1 MBurial 2 Cremation 3 Removal from State  14 Donation 5 Other (Specify)  Md. Veterans Cem. 12-03-	te 20c.	Location - City or Town, State
Baltimore permit. Pages 1. Depertment of He Importent: if ten any injury or oth		4 □Donation 5 □Other (Specify)  Md. Veterans Cem. 12-03-2  21. Signature of Funeral Samilee Licensee  22. Name and Address of Facility Bennie Smith Funera 426 dover Street,		clock,Maryland
Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a	respiratory arrest,	Approximate Interval Between Onset and Death
8760, ate be executed tysicien and the burial-transit	ilcal Examiner	Sequentially list conditions, if a y, leading to maintain cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.		
I Records, P.O. Box 68760, The law requires that the death certificate be executed atte has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)		23d. Date of delivery Month Day Year
BBB BBB BBB BBB BBB BBB BBB BBB BBB BB	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  PACOXY(ms/ATX/A/Fibra/14776) ON Coverndo	23e. Did tobacce 1 ☐ Yes	o use contribute to the cause of death?  2  No 3 Probably 4 Unknown
ital Reco	Completed	ANTI COASULATRAS	24a. Was an autopsy performed?	
of V	tlon; To Be	27. Mann Teath       28a. Date of Injury       28b. Time of Injury       28c. Injury at Work?       28c. Injury at Work?       28c. Injury at Work?		6 □Other (Specify) jury occurred
DIVISION Lator Attending s after death. Is Director: Afte	Certification:	2 Suicide 6 Could not be	f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
the Hospit nin 24 hour the Funera	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	I at the time, date a	and place, and due to the cause(s)
To To To con	Σ	29b. Signature and title of certifier  29c. License number  D 3 1966	29d. E	Date signed (Month, Day, Year)
Sta	to	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Ludwig Vglseder M D ,503 Cynwood Drive, Easton, Maryla 31. Date filed (Month, Day, Year)  32. Registrar's Signature	and 2160	1
Registr DHMH 17 Rev 1/20	ar	NOV 3 0 2004 Later S. Sparks		

			1 - For State Registrar	State of	Maryland / D		irtment of H tificate of L			giene Rag. No.	04	39071
	Physici		Decedent's Name (First, Middle,     JUNE A. SINES	Last)					2. Date of De Month	ath Day	Year 2004	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution,				4b. City, Town, or		November Heath	4c. Co	unty of Death	1:35 P
	Funeral Director		Salisbury Rehab 5. Social Security Number 216-22-4230		7. Age (In yrs. last birt	hday) Yrs.	Salisb If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Bin (Month, Da 04-18-	h	Cou	place (State or Foreign ntry) LMORE, MD.
	e Maryland 3a-f show	Director	Usual Residence of Decedent	OMICO	10c. City, Town		cation					10d. Inside City Limits 1 ☐ Yes 2 XNo
	h with th		10e. Street and Number 32431 MT. OLIVE	ROAD			10f. Zip Code	1804		10g. Citizen	of What Coul	ntry?
980	72 hours after death with the Maryland natural', or Items 23a or 28a-f show disal Examiner must be notilised at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Marrie  3 ☒ Widowed 4 □ Divorced	Armed For	2 ☑ No e	li li		spanic Origin	? (Specify Yes or No uerto Rican, etc.)		Race - Americ Black, White,	etc.
21215-0036	within ane. than *	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)			(Give I life. E	ent's Usual Occupa kind of work done d OO NOT use retired, HOMEMAKER	uring most of	working	16b. Kind	of Business/In	
Maryland 2	should be filed nd Mental Hygie marked other imatic event, III	To Be Co	17. Father's Name (First, Middle, L JAMES WILLIAM AT	,					Name (First, Middle,	Maiden Sui		ONE
	1 and 2 sho Health and N Iem 27 Is me	•	19a. Informant's Name/Relationshi SANDIE LITSINGE						Rural Route Number	•		,
Baltimore,	permit. Pages 1 a Department of Hes Important: If Item any injury or othe		20a. Method of Disposition 1 XBurial 2 □ Cremation : 1 4 □ Donation 5 □ Other (Spe		20b. Place of cemeter)	Dispos y, crem	sition (Name of natory or other place L MEM GDN	)	Date	20c. Locati	ion - City or To	own, State
Balt	permit. Departr Importe any inji		21. Signature   Funeral Service L	SK	lly	7	Name and Address	AIN ST	BOUNDS FU	NERAL SBURY,	HOME,	INC.
	Physician		23a. Part1. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	omplications that can on each	used the death. Do not high line.	ot ente	or the mode of dying		diac or respiratory ar	rest,	y	Approximate Interval Between Onset and Death
	Medical Examiner  bhysician and strengit in the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter this straight and the straight and t	b. Due tr (	as a consequence of a conseque	f):	in in				74-1	907-7
68760,		edicai	IE EEMALE.	d.								
P.O. Box	the death certifi y the attending pached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live bi	ome of pregnancy th 2  Fetal death ant at time of death wn		Ectopic pregnancy Other (specify)			23d.	Date of delive Month	ny Day Year
	law requires that the de as been signed by the a 2 should be detached f	þ	Part II. Other significant condition	s contributing to de	ath but not resulting in	the un	derlying cause give	n in Part I.			contribute to the	ably 4 Unknown
al Records,	The te h	Completed				_			24a. Was autop perfor 1 🗆 Yes	sy med?	4b. Were autoprior to condeath?	psy findings available inpletion of cause of
of Vital	iding Physiciant Th th. : After this certificate funeral director, pag	To Be	25. Was case referred to medical examiner?  1  Yes 2 No		patient 2 ☐ ER/Out	patient	3□ DOA Othe	4 Nursin	Death <i>Check onloo</i> g Home 5 Resid		Other (Specify	')
Division of	tending Pieath. tor: After the funera	Certification:	27. Manner of Death  1 Autural 5 Pending 2 Accident investiga 3 Suicide 6 Could no	nt be		jury		at ? es 2 □ No	28d. Describe h			
Divi	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer		4 Homicide determin	ed 288. Place buildin	of Injury - At home, fan g, etc. (Specify)				City or Tow	n, State)		l Route Number,
	the Hos	ledical	one)	xaminer: On the ba	pest of my knowledge, sis of examination and er stated.	death Vor invi	occurred at the time	e, date and pl nion, death o	ace, and due to the c ccurred at the time, c	ause(s) and late and plac	manner as st ce, and due to	ated. the cause(s)
	with To Con	M	29b. Signature and title of certifier	Mars			29c. License	number 5	9	29d. Date sig	gned (Month, I	Day, Year)
			30. Name and address of person w William H.j Robi	ns, M.D.			rint) Ave. Sali	sbury,	MD 21804	I	11	
ì	Sta Registr	100	31. Date filed (Month, Day Year)	2 2004 32. Re	gistrar's Signature	19	Sport	h				

			For State Registrar	nd Me	Mental Hygiene 2004 3907;										
	Physici /Medio		1 - State Registrar Certificate of Death  1. Decedent's Name (First, Middle, Last)  Charles W. Sturgis							Date of Dea Month	ath Day	Year	3. Time of 3:45 A		
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  Salisbury Nursing and Rehab Center  Salisbur							4c. County of Death				<u>rı</u>	
	C # 00 F		5. Social Security Number  221–12–4314  Usual Residence of Decedent	(In yrs. last b	In yrs. last birthday) If Under 1 Yes.  Yrs. Months Day			Min.	Date of Birth (Month, Day Feb 5,	y, Year)	Birthplace (State or Foreign Country)  MD				
		Funeral Director	10a. State 10b. County MD Wicon	nico	10c. City, Tov	wn or Location bury							10d. Inside Cit	1	
			10e Street and Number 330 Delaware Avenue, Apt. 2				10f. Zip Code 21801				10g. Citizen of What Country?				
36		by Fune	11. Marital Status  1 □ Never Married 2 □ Marr 3 □ Widowed 4 ☑ Divorced	12. Was Decedent E Armed Forces? ied 1 ☑ Yes 2 □ N If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puer				n? (Specif Puerto Ric				- American Indian, , White, etc. Black		
STURGIS Maryland 21215-0036		Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of workil life. DO NOT use retired)									
3IS and 21		Be						18. Mother's		Agriculture ame (First, Middle, Maiden Sumame)					
STURGIS Maryland		ည	Robert Sturgis  Filnora Tingle  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Arthur Sturgis/nephew  10546 Harrison Rd., Berlin, MD 21811												
HRLES W. Baltimore,		- Company	20a. Method of Disposition  1 Description   20b. Place of Disposition (Name of cametery, crematory or other place)  1 Donation   5 Other (Specify)   MD Veterans Cemetery   11/2						Date	9	20c. Location				
CHRLES   Baltim			21. Signature Funeral Service Licensee  22. Name and Address of Facility  Lewis N. Watson Funeral Home												
8760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and Director. After this certificate has been signed by the attending physician and Director. Page 2 should be detached for use as the burial-transit of Director.		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Due to (or as a consequence of):												
		dical Examiner	Sequentially list conditions, if any, reaching to monoculate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	consequence of):						year					
Division of Vital Records, P.O. Box 68		Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t	Fetal death	n 3 ⊟Ectopic p 5 ⊡ Other (s <sub>j</sub>						ate of delive	,	ear	
rds, P		by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Onknown					
I Reco		Completed							_	24a. Was a autops perform	in 24b. Sy med? 2. 19 No	Were autoprior to condeath?	psy findings at appletion of car	vailable use of	
ı of Vita		To Be	Axaminer?  1 Yes 2 140 Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 140 Nursing Ho  27. Manner of Death  28a. Date of Injury.  28b. Time of 28c. Injury at								h (Check only one)  me 5  Residence 6 Other (Specify)  28d. Describe how injury occurred				
Division	or Attending Fatter death. Director: After in by the funera	Certification;	2 Accident investigation M 1 Yes 2 No						28f.	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
_	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al completely filled in by the fu	Medical Ce	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
	Total Within		29b. Signature and title of certifier  29c. License number							29d. Date signed (Month, Day, Year)					
	VA		30. Name and address of person v  William H  31. Date filed (Month, Day, Year)	Robins	d.n				c Av	e.,Sal	isbury	, Md.	21804		
	Sta Registra		NOV 2	2 2004 32. Registrar	's Signature	B A	pa	les							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month CLIFFORD EARL STANLEY NOVEMBER 20, 2004 6:10 A<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Months 1**▼**M 2□F 84 349-12-8124 Director Yrs. JUNE 8, ILLINOIS Usual Residence of Decedent the Maryland 10a State 10b. Count 10c. City, Town or Location r Itams 23e or 28e-f show ther must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 👿 No MD QUEEN ANNE'S **STEVENSVILLE** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 211 ALLEGANY ROAD Pages 1 and 2 should be filed within 72 hours after death vant of Health and Mental Hygiena.
and: If item 27 is marked othar than "natural", or Itams 23s.
ury or othar traumatic avant, Ita M. Alfed Ex. Illing multing 21666 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 NYes 2 □ No 1941— If Yes, Give Year or Dates: 1945 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 WATERPROOFER/UNDERCOATER AUTOMOTIVE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ENNIS STANLEY 2 MARIE BAKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RUTH STANLEY/WIFE 211 ALLEGANY ROAD, STEVENSVILLE, MD 21666 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State CROWNSVILLE VETERANS 11/23/2004 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. \*4 ☐ Donation 5 ☐ Other (Specify) CROWNSVILLE, MD 21. Signature of Funeral Service License FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition 11-418resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) Cause (Disease or injury The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physiclan/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d Date of delivery 3 □Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. | the detached 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ page 2 should be Completed 1 Yes 3 ☐ Probably 4 ☐ Unknown 24a. Was an .24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 2 🗀 No 1 Yes 2 No Hospital or Attanding Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation M 1 ☐ Yes 2 ☐ No after death 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours To the Funarel 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Chack only onel tha 29b. Signature and title of certifier 0 29d. Date signed (Month, Day, Year)

Registrar

State

31. Date filed (Month, Day,

30. N and address of person who completed cause of death (Item 23a) (Type, Pript)

2004

Year)

32. Regis

ar's Signature

1			1 - For Unpersonal State Registrar A	end Ite mend It	m 23a .em 23	tate of Pt.I Bot.II	Maryla Der	ле G8	partn gytifi	nent of decate of	lealth Death	274_( 71-24	lental Hy 74 Cas -05 tas	gien Reg. N	001	4 (	39074
	Physici /Medio		Decedent's Nam	e (First, Middle Lse Leni	, Last)								2. Date of D Month Novemk	eath			3. Time of Death 0705A • M
	Examir		4a. Facility Name (		•					city, Town, o Lanham	r Location	of Death		]	c. County of I Prince		rges
17	Funeral Director		5. Social Security N 227-54-7	328	6. Sex 1 ☐ M		. Age (In y	rs. last birthd Yrs	Mo	Inder 1 Year oths Days	If Unde Hours	Min.	8. Date of Bi (Month, D <b>Decemb</b>	rth lay, Year er 2	935 9. 25 <b>V</b>	Birthplac Country irgi	ce (State or Foreign nia
7	show		Usual Residence o 10a. State	10b. County				City, Town o	r Location	ר -						100	I. Inside City Limits
	e Ma	cto	MD	Princ	e Geo	orge's	3	Capi	tal	Height	S						1X Yes 2 No
	or 24	Director	10e. Street and Nu						10	f. Zip Code				_	itizen of Wha		/?
	s 23s			/alley						20743					U.S.A.		
36	72 hours after death with the Maryland Instural', or Items 23a or 28e-1 show dital Examinar must be rodified at	by Funerai	11. Marital Status  1 ☐ Never Marr  3 ☐ Widowed		ied i	Was Deced Armed Ford I □Yes 2 If Y <i>es</i> , Give Year or Dat	es? No	n U.S.		es 2 XNo	lispanic O an, Mexica Specify		ecify Yes or N Rican, etc.)	0-	14. Race - A Black, \ Specify:	White, etc	
5-0036	72 hours natural', lical Ex		(Spec	15. Decedent	's Education	on				Usual Occup		et of worki	na.	16b. h	Kind of Busin		
2121	within ane. than '	Completed	Elementary/Seco	ondary (0-12)		College (1-4	4or 5+)	lif	ө. <i>DO N</i>	OT use retired	d) "19 1110	or or work	ng .		Privat	_	
9	tygent,		17. Father's Name		Last)			DI.	LI A	juster	18. Moth	ner's Name	(First, Middle			e	
/lan	should be nd Mental marked c	To Be	Fleming	R. McC	юу							Mary	Moore				
Maryland			19a. Informant's N			,			_				l Route Numb				ode)
	as 1 and 2 of Health item 27 I		Casaunda 20a. Method of Dis		tmire	/Daug		992 b. Place of Di			eet		m, Mar		d 2070 ocation - City		State
Baltimore,	permit. Pages: Department of H Important: If ite any injury or ot		<b>\1</b>	Cremation		val from St	ate	cemetery, d	remator	or other place		12/2			ndover		
計	permit. P Departme Importan any injur		21. Signature of Fu		1	_							B. Jen				
ä	# 5 E 8	(		6			/		747	4 Lando	over	Road	Landov	ær,			
68760,	Physician and // Medical Examiner as the puriar-transit	edical Examiner	23a. Part1. Enter shock, or has Immediate Cause disease or condition resulting in death)  Sequentially list or cause. Enter Unde Cause (Disease or that initiated events resulting in death)	(Final on	Ç	Due to lo	SCOPY r as a cons	ons Ui	Aspi	ration	) Dur	ing E	Explora	tory			iterval Between
P.O. Box 68	the death cert by the attending ached for use a	Physician/Med	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 25 9 Whitnown	months?		f yes, outco 1 □ Live birt 4 □ Pregnar 9 □ Unknow	th 2 □ Fo nt at time o vn	etal death of death	5 Othe	pic pregnancy or (specify)					23d. Date of Month	f delivery Da	ay Year
	quires that n signed t uld be det	-	Part II. Other signi Pulmonary	Absces	ses:	thero	th but not r scler	resulting in the	ardi	ing cause give ovascu leroti	en in Part Lar	Disea	se <sup>23e. Did</sup>				cause of death?
of Vital Records,	: The taw requir cate has been si page 2 should	-	Sardiovas	eulor									24a. Was auto perfe 1 Yes		prior	to comp h?	r findings available letion of cause of
Vita	yslcien: T is certifical director, p	Be	25. Was case reference examiner?		Hospi	ital:				7 DOA Oth			(Check only				
	Phys r this ral di	T.	1 XYes 2 2			i 🗆 inp		ER/Outpa 28b. Timi		J DOA	4 🗀 14		ne 5 Res			Specify) unk	·
on	nding ith. : After e funer	ation	1 Natural 2 Accident	5 Pending	9	8a. Date of (Month, 1-22-				28c. Injun Worl	k? Yes 2 <b>▼</b>				y oooanoo	uiir	
Division		Certification;	3 Suicide 4 Homicide	6 Could r determi	not be	8e. Place o		t home, farm,				2	28f. Location ( City or To		9929 1	ark	Street
	Fur Per	edical	29a. Certifier (Check only one)	1 Certifyin 2 Medical	g Physicia Examiner:	n: To the b	is of exami	knowledge, de ination and/o	ath occu	arred at the tin	ne, date a pinion, de	nd place, a	and due to the ed at the time,	cause(s date an	i) and manne d place, and	or as state due to th	ed. e cause(s)
	To the within 2 To the complet	M	29b. Signature and	title of certifier						O.C.M					ite signed (M Tember		
K			30. Name and add		who comple	MO					enn	Stree	et, Bal	timo	ore, Ma	aryla	and 21201
	Sta Registr		31. Date filed (Mon		2004	32 Aeg	jistrar's Sig	gnature	fool	9							

State of Maryland / Department of Health and Mental Hygiener 39075 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year CORY ETHAN SUNSHINE November 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 11/16/2004 Social Security Number unk 6. Sex 7. Age (In yrs. last birthdey) Birthplace (State or Foreign
Country) **Funeral** 1 XM 2 ☐ F Director 0 MARÝLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itams 23s or 28e-1 show If w Medicul Examinar must be notified at 1 Yes 2 No Directo MARYLAND MONTGOMERY BOYDS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18206 ENDORA CIRCLE 20841 U.S.A. death Funerai 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: ð WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) NONE NONE permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic aveni once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) DOUGLAS SUNSHINE RACHEL LANDSBERG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOUGLAS SUNSHINE/FATHER 18206 ENDORA CIRCLE, BOYDS, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

'4 ☐ Donation 5 ☐ Other (Specify) JUDEAN MEMORIAL GDNS 11/21/2004 OLNEY, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
EDWARD SAGEL FUNERAL DIRECTION, INC.
1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 Part 1. Inter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician deys /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Erner underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached t 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 2 🗆 No 3 ☐ Probably 4 ☐ Unknown been si 1 ☐ Yes 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? certificate has birector, page 2 s 2 No 1□ Yes 2ŪNo 1 Yes Division of Vital To the Hospital or Attending Physicien: atter death.

Diractor: After this certitic 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 1 ☐Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours atter der To tha Funaral Diracto completely filled in by th 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide † Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nter Dr. 99 VESZEL Medi 31. Date filed (Month, Day, Y NOV 2 32. Pegistrar's Signature State Registrar

			1 - State of Maryland / [	•	rtment of H tificate of L		ind M	ental I		200	4	39076
			Decedent's Name (First, Middle, Last)					2. Date o		Day	Year	3. Time of Death
	Physicia /Medic		Oscar Antonio Salazar							21, 20		10:16 <sup>ам</sup>
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location o	f Death			4c. County of		
			Montgomery General Hospital	4. ()	Olney If Under 1 Year	If Under :	24 Hrs	0.0	( D) 41	Montg		3
	Funeral Director		5. Social Security Number 6. Sex 1 ★ 1 ★ 1 ★ 1 ★ 1 ★ 1 ★ 1 ★ 2 ★ 1 ★ 2 ★ 1 ★ 3 ★ 1 ★ 3 ★ 1 ★ 3 ★ 1 ★ 1 ★ 1 ★ 1		Months Days	Hours	Min.	8. Date o (Month June	, <i>Day</i> , Y		Cou	place (State or Foreign Intry) La Rica
	p		Usual Residence of Decedent  10a. State 10b. County 10c. City, Tow	! -								404 12-14- 015-11-15-
	anylar ehov	_										10d. Inside City Limits 1 ☐ Yes 2 XNo
	Pan-f	Director	Maryland Montgomery Silve  10e. Street and Number	r S	pring 10f. Zip Code				100	. Citizen of W	lhat Cau	
	with		3307 Densmore Court		20906				109	USA	nat ooc	indy.
	ns 23	Funerai	11. Marital Status 12. Was Decedent Ever in U.S.	13. V	Vas Decedent of Hi	spanic Orig	gin? (Spe	cify Yes o	r No-		- Amen	ican Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23a or 28a-f ahow amy injury or other traumatic event, the Mcd field Examinar must be notified at ance.	by Fun	Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 □ No  If Yes, Give  Year or Dates:	If	Yes, specify Cuba	n, Mexican	, Puerto	Rican, etc.	)	Specify:	white White	
Maryland 21215-0036	2 hou	ted		. Deced	ent's Usual Occupa	ition	of worki	n.a	16	6b. Kind of Bus	siness/Ir	ndustry
215	thin 7 e. an "n Med	pie	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	life. C	OO NOT use retired	uring mosi	OF WORK	ng				
7	ed wi	Completed		Pro	fessor	12 (0				Educati		
ğ	be fill H of other of other of other	Be	17. Father's Name (First, Middle, Last)							iden Sumame	∍ <i>)</i>	
2	hould d Mer marke martic	10	Oscar Antonio Salazar Mora  19a. Informant's Name/Relationship (Type, Print)  19b	Mailin	g Address (Street a			oe Va			State 7i	in Code)
<u>8</u>	d 2 si th an traur		Tili- T G-1/ Wi-6-		Densmore					13,64		
ē,	tem		20a Method of Disposition 20b. Place 0	f Dispos	sition (Name of			ate	20	c. Location - (		
Ē	Pages ent of		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State MC t  '4 ☐ Donation 5 ☐ Other (Specify)	ropo	natory or other place of litan tory	" ; I		ber 004		.exandr	ia.	Virginia
Baltimore,	permit. I Departm Importal any inju		21. Signature of Funeral Service Licensee	F22	Name and Addres	Collin	ns I	uner W.	al H	Home In	С	MD 20901
			23a. Ranti. Enter the disease, or complications that caused the death. Do									Approximate
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	4	+ E.l.	2.040						Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  a  Due to the as y consequence	of):	1 /01/10	E						
	Examiner		Sequentially list conditions, b. forthe Sta	70 S=	<u>`</u>							
	sit sd	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	of):								
	and and I-trans	Examiner	that initiated events resulting in death) Last	of):								
8760,	icate be executed physician and the burial-transit	aiE		,-								
687	ficate p physis the	edicai	d									
Box (	nding nding use a	N/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	• -						23d. Date	of deliv	rery
m m	The law requires that the death certificate has been signed by the attending I agge 2 should be detached for use as	Physician/M	in the past 12 months?  1   Yes 2   Ser No 9   Unknown		Ectopic pregnancy Other (specify)				_	Mon	th	Day Year
P.0.	at the	Phy	9 Unknown	- 45		- i- P-+l		220 (	and taba		huta ta i	the cause of death?
	w requires that been signed b should be det	by	Part II. Other significant conditions contributing to death but not resulting in	n the un	ideriying cause give	ının Parti.			I □ Yes			bably 4 DUnknown
Ö	need peen	etec	D. I The factor of						-			
Records,	has has by	Completed	Wig stales toxicity						<b>Va</b> s an lutopsy lerforme	d? pr	rior to co eath?	opsy findings available ompletion of cause of
			25. Was case referred to medical			OC Place	-4 D4h	1 V	es 25	No 1	Yes	2 No
Vita	Physician: rthis certificanal director,	To Be	examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Ou	utpatien	t 3□ DOA Othe	VE.				ce 6 □Othe	r (Speci	(fv)
o			27. Manner of Death 28a. Date of Injury 28b.	Time of	28c. Injury Work	at	7.1			injury occurre		97
jo	Attending I r death. ector: After by the funer	atio	2 Accident investigation	пјагу		/es 2 □ I	Vo					
Division	or Atterde afterde Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	ırm, stre	et, factory, office		1		on (Stre Town,		r or Rur	al Route Number,
	urs af					- 4-1	1.1.		the e			
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one)  2   Medical Examiner: On the basis of examination ar and manner stated.	e, death	estigation, in my op	e, date an pinion, dea	u piace, i th occurr	and due to ed at the ti	me, date	se(s) and mar e and place, a	ner as s	stated. to the cause(s)
	To the To the	Me	29b. Signature and title of certifier		29c. License				290	I. Date signed	(Month,	Day, Year)
			I All		221	334			1	Vovene	10-	21,2005
	10		30 Name and address of person who completed cause of death (Item 23a)	(Type, I	Print)   R	t	110	mi	2	2084	52	21,2004
	Sta	to	31. Date filed (Month, Day, Year) 32. Registrar's Signature	. 07	1		1.2	) "		2000		
	Sta Registi		NOV 23 2004 Spread /	9	Sparks							

		1- For State of Maryland / Dep	partment of Health and Mental Hygertificate of Death	iene 004 39077
		Decedent's Name (First, Middle, Last)	2. Date of Deal Month	
Physi /Med	ician dical	Robert Kriete Sellers, Jr.	November	r 19, 2004   9:45 p. <sup>™</sup>
Exam	niner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
		Mallard Bay Care Center  5. Social Security Number 6. Sex. 7. Age (In yrs. last birthda	Cambridge  V) If Under 1 Year   If Under 24 Hrs.   8 Date of Birth	Dorchester
Funera Directo		5. Social Security Number 6. Sex, 7. Age (In yrs. last birthda 79 Yrs.	y) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, August	(Year) 9. Birthplace (State or Foreign Country) 8, 1925 Maryland
	1	Usual Residence of Decedent	August	o, 1929 Paryland
ryland		10a. State 10b. County 10c. City, Town or		10d. Inside City Limits
) M M M M M M M M M M M M M M M M M M M	Director	MD Dorchester	Cambridge	1 ☐ Yes 2 No
(1213-5-0036 // (C.) within 72 hours after death with the Maryland ene than "natural", or items 23a or 28a-f show than "natural", or items 23a or 28a-f show	i Dire	10e. Street and Number 2066 Dailsville Road	10f. Zip Code 21613	0g. Citizen of What Country? USA
death	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. 13 Armed Forces?	B. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
5-UU36 72 hours after natural; or ite	by Fu	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 🗖 No Specify:	Specify: white
15-UU36 72 hours aff "natural", or		3 Widowed 4 Divorced Year or Dates: WWII  15. Decedent's Education 16a. Dec	edent's Usual Occupation	16b. Kind of Business/Industry
10 72 in 72 and in 72	piete	(Specify only highest grade completed) (Gin	ve kind of work done during most of working  . DO NOT use retired)	100. Kind of Business/fidustry
V	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 8 Mac	chinist/welder	automotive
and Z d be filed ental Hygie ked other c event, to	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, I	
Aarylan 2 should be 2 should be 3 and Mental 1s marked or	2	Robert K. Sellers	Mary Stincho	
IOCE, Maryla ges 1 end 2 should tt of Health and Men if frem 27 1s marke or other traumatic			iling Address (Street and Number or Rural Route Number 56 Dailsville Road, Cambric	
e, n 1 end Health em 27 ther t				age, MD 21613  20c. Location - City or Town, State
Baltimore, Mi permit. Pages 1 end 2 Department of Health a Important: If item 27 is		1 Burial 2 Cremation 3 Removal from State	rematory or other place)	Salisbury, MD
nit. P artme ortani injury	oi			neral Home P.A.
Deg de la constant de	buce	Barrie K. Russ	700 Locust St., Cambridge	
		23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	inter the mode of dying, such as cardiac or respiratory arro	est, Approximate Interval Between
Physicia	n		vance Dementi	Onset and Death
/Medica Examine	_	resulting in death)  Due to (or as a consequence of):		
LAGITITIC	■.	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of):		
ted nslt	nine	cause. Enter Underlying Cause (Disease or injury		
60, be executed sician and burial-transit	Examin	that initiated events resulting in death) Last C. Due to (or as a consequence of):		
OX 68/6U, certificate be executed ading physician and use as the burial-transli	cai	d		
rtifica ng ph	70	IF FEMALE:		
IS, P.O. BOX 61 res that the death certific igned by the attending p be detached for use as it	hysician/Me	23b. Was decedent pregnant in the past 12 months?	3 □Ectopic pregnancy	23d. Date of delivery  Month Day Year
he degraphed the a	ysic	1 □ Yes 2 □ No 4 □ Pregnant at time of death 5 9 □ Unknown	☐ Other (specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
that the detack	٥	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did tot	pacco use contribute to the cause of death?
Ords, P.O. requires that the een signed by the	d by		1 □ Y€	es 2 146 3 Probably 4 Unknown
() > 0 0	lete		24a. Wasa	n 24b. Were autopsy findings available
The lay ate has page 2	ompleted		autops perform 1 ☐ Yes 2	prior to completion of cause of death?
VITAL F iclan: Th certificate rector, pag	S S	25. Was case referred to medical	26. Place of Death (Check only on	
d s	To B	examiner? 1   Yes 2   Hospital: 1   Inpatient 2   ER/Outpate	ent 3 DOA Other: 4 Nursing Home 5 Reside	ence 6 Other (Specify)
		27. Mann of Death 28a. Date of Injury 28b. Time (Month, Day Year) 1 Matural 5 ☐ Pending (Month, Day Year)	/ Work?	ow injury occurred
VISION Attending r death. ector: After by the funer	cati	2 Accident investigation 3 Suicide 6 Could not be 288 Place of Injury. At home farm	M 1 Yes 2 No	reet and Number or Rural Route Number,
DIVISION or Attending efter death. Director: Atte	ertification;	3 Suicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	City or Town	
UN To the Hospital or / within 24 hours efter To the Funeral Dire completely filled in b	edical C	29a. Certifier (Check only (Ch	investigation, in my opinion, death occurred at the time, da	ate and place, and due to the cause(s)
thin 2 the l	Med	one) and manner stated.  29b. Signature and title of certifier.	29c. License number 2	9d. Date signed (Month, Day, Year)
¥ ¥ 5		Miller MD	047924	11.22.04
		30. Name and address of person who completed cause of death (Item 23a) (Tvo	e, Print)	2 //
		NOMAN THANKY 300 AURORA	ST CAMBRIDGE MD	2/6/3
	State	and manner stated.  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Typ NOMAN THATES Y 300 AUROLA  31. Date filed (Month, Day, Year)  NOV 2 3 2004  32. Relistrar's Signature	hearts &	
Regi	strar	THE TOTAL SOLUTION SOLVED SOLV		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Edward Samuel 0708AM NOULMBER 21 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner DORCHESTER CAMBRIDGE HOSPITAL DORCHESTER GENERAL If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Oct. 22, 1914 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**⊠**M 2□ F 90 214-07-9014 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23e or 28a-f show 1 XYes 2 □ No Director MD Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 406 Kent St. 21613 Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Specify. þ 3 ¥ Widowed 4 □ Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) welder construction 6 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Annie Elliott Valentine McOuay Spear 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 ie any injury or other trau once. Ronald Spear son 406 Kent St., Cambridge, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location · City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dorchester Memorial Park 11/24/04 Cambridge, MD 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service bicensee 700 Locust St., Cambridge, MD 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Arterioscierate Heavi-**Physician** /Medical Due to (or as a consequence of): Examiner Advance Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, attending physician by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No o 9 Unknown 9 Unknown Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 2 No 2 100 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 10 1 Dinpatient 2 ER/Outpatient 3 DOA Certification; To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

nours after death.

nerel Diractor: After this
filled in by the funeral d within 24 hours a

> NOMAN TITANWY 300 AURDRA ITREE! 31. Date liled (Month, Day, Year) 32. Regitrar's Signature State NOV 23 2004 Registrar

30. Name and address of person who completed caute of death (Item 23a) (Type, Print)

29a. Certifier

29b. Signature and title of certified

Medical

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year) 11.22-04

CAMBRICKE MD

31		1- State Registrar Item#4a,4b,per dr,QACHD,11/30/04	•		ental Hygier	
Physici	an	1. Decedent's Name (First, Middle, Last)  JAMES ELWOOD TIMMS, III			2. Date of Death  Month  NOVEMBER	Day 2004 2:40 P M
/Medi Examir	er	4a. Facility Name (If not institution, give street and number .18 & I University-of-Mary-land Medical-Co	Dundee Athecity, Tow enter -Balt	n, or Location of Death	4	4c. County of DeathN/A Queen Anne
Funeral Director		5. Social Security Number  216-29-0664  1 ▼ M 2 □ F  7. Age (In yrs. last 1 ▼ M 2 □ F ■ 17	st birthday) If Under 1 Y Months D	ys Hours Min.	8. Date of Birth (Month, Day, Yea) OCT. 1, 19	9. Birthplace (State or Foreign Country)  MARYLAND
Maryland a-f show	tor		Town or Location  ENSTOWN			10d. Inside City Limits 1 ☐ Yes 2 X No
vith the	Direc	10e. Street and Number	10f. Zip Co			Citizen of What Country?
is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It was 12 is marked other then "natural", or Itams 23a or 28a-f show other traumatic event. Its Medical Examinations in the notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		of Hispanic Origin? (Spec Cuban, Mexican, Puerto F	cify Yes or No- lican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE
ed within 72 hours aff giene. ar than "natural", or . I'm Wedical Exam	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  10  College (1-4or 5+)	16a. Decedent's Usual O (Give kind of work a life. DO NOT use n	one during most of workin	9	Kind of Business/Industry  ONSTRUCTION
nd 2 should be filed lith and Mental Hyg 27 Is marked otha rtraumatic event,	To Be C	17. Father's Name (First, Middle, Last)  JAMES ELWOOD TIMMS, JR.		18. Mother's Name VIVIAN I	(First, Middle, Maid DARLENE EV	•
2 sho	i a	19a. Informant's Name/Relationship (Type, Print)				y or Town, State, Zip Code)
iges 1 and at of Health it of Health or Other t		1 ■ Burial 2 □ Cremation 3 □ Removal from State	ice of Disposition (Name of metery, crematory or other	place)	ate 20c.	Location - City or Town, State
permit. Pages 1 an Department of Heal Important: If itam 2 any injury or othar		3 □ Other (Specify)  21. Signal □ V=uneral Service Licensee	ZENSVILLE CEI  22. Name and A  FELLOWS,  106. SHAM	dress of Facility	& NEWNAM	EVENSVILLE, MD  FUNERAL HOME, P.A. MD 21619
death certificate be executed  Wedgical Exammine and death of the burial-transit and for use as the burial-transit	dicai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the consequen	ence of):	Muries		Onset and Death
	Physician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal of the pregnant at time of dearence.	death 3 Ectopic pregn			23d. Date of delivery Month Day Year
requires that the been signed by th hould be detache	b	Part II. Other significant conditions contributing to death but not result	ting in the underlying caus	given in Part I.		o use contribute to the cause of death? 2 \( \sumbox{No} \) 3 \( \sumbox{Probably} \) 4 \( \sumbox{Unknown} \)
he law e has t	Completed				24a. Was an autopsy performed?	
To the Hospital or Attending Physician: The within 24 hours after death.  To the Funaral Diractor: After this certificate completely filled in by the funeral director, page.	edical Certification: To Be	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  27. Manner of Death 5 Pending investigation 6 Could not be determined 28e. Place of Injury - At hom building, stc. (Specify) 28e. Place of Injury - At hom building, stc. (Specify) 27 Medical Examiner: On the basis of examinatic and manner stated.	Plage, death occurred at ton and/or investigation, in	injury at 2 Work?  1 □ Yes 2 ☑ No 2  ice 2  te time, date and place, a ny opinion, death occurre	Residence  8d. Describe how in  ASSAULE  8f. Location (Street City or Town, Sta  TIBC DUM  due to the cause d at the time, date a	Nitry occurred  OF Will VAN STYLL POLE and Number or Rural Route Number, And Pole (S) and manner as stated. and place, and due to the cause(s)
To the within to To that a To that comple	2	29b. Signature and title of certifier  Many and address of person who completed cause of death (Item)	9	O.C.M.E.		Date signed (Month, Day, Year)  Vember 20, 2004
2 KF		30. Name and address of person who completed cause of death (Item 2)  Why D MW D. W. Fu  31. Date filed (Month, Pay, Year)  32. Registrar's Signatu	111 Penn S	treet, Balti	more, Mai	ryland 21201
St Regist	ate rar	31. Date filed (Month, Day, Year) 32. Redistrar's Signatu	1 Snorth			

				State of Maryland / Department State of Maryland / Certificate	nt of Health and Me te of Death		en2e004 39080
		ysiciar Medica	1	1. Decedent's Name (First, Middle, Last) William E. Tennant		Date of Death Month	Day 24 Year O319AM
	E: Fur	camine neral	r	Memorial Hospital at Easton  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under	Town, or Location of Death  T Year If Under 24 Hrs. 8.  Days Hours Min.	. Date of Birth (Month, Day, ) 8 – 1 2 – 1	4c. County of Death  7 9. Birthplace (State or Foreign Country)
		ector		214-34-5852	3	8-12-1	932 Easton, MD.
	e Maryla 3a-f shov	an paying an	2013	MD Talbot Easton		-	1 X Yes 2 No
( *	th with th	direcmust be notified	מו חוב	10e. Street and Number 210 N. Aurora St. 21	1601	109	g. Citizen of What Country? USA
3 K	d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. thar than "natural" or Itams 23e or 28e-f show	3	2	11. Marital Status  1 Never Married  2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, Spe  1 Yes, Spe  1 Yes, Give  Year or Dates:  13. Was Decedent Ever in U.S.  Armed Forces?  1 Yes, Spe  1 Yes, Give  Year or Dates:	dent of Hispanic Origin? (Specif cify Cuban, Mexican, Puerto Ric 2 X No Specify:	fy Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc. Spelichite
19	215-000 Ithin 72 hours e.		Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0·12)  College (1·4or 5+)	al Occupation ork done during most of working ise retired)	16	6b. Kind of Business/Industry
11	nd 212.  I Hygiene.  other then			12 years Waterman  17. Father's Name (First, Middle, Last)	18. Mother's Name (F		Seafood aiden Sumame)
3	arid be	traumatic avan	0	Samuel Hambleton Tennant  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address	Anna Lee		
tra	and and salth	Ē		Transco Zi zo	s (Street and Number or Rural A Aurora St., ]		
ζ	2 o o	-		20a. Method of Disposition  1 □ Burial 2 □ Premation 3 □ Removal from State  1 □ Donation 5 □ Other (Specify)  20b. Place of Disposition (Naicemetery, crematory or a completely, crematory or a completely.	other place)		Oc. Location - City or Town, State  Dover, De.
161	Balti Permit Departm	any injury o Q. S.		P. Ca	nd Address of Facility rroll Hurley	Funer	al Home,PC
1	Physi			23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter he moshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a	Bodying, such as cardiac or re eng Hovest	Micha espiratory arres	Approximate Interval Between Onset and Death
	760, te be executed visician and		dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):   en, Dissase	,	5 jeors -	
	P.O. Box 68760, hat the death certificate be end by the attending physician	ched for use as the	rnysician/med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1			23d. Date of delivery Month Day Year
	ords, P.	should be detached	2	Part II. Other significant conditions contributing to death but not resulting in the underlying of	ause given in Part I.		accoluse contribute to the cause of death?
	Recc he law re	ige 2 sh	Completed	Hypertensin		24a. Was an autopsy performs	
	Vital	director, page	9	25. Was case referred to medical examiner?  Hospital:	26. Place of Death (C		
	Division of Vital Records, tor Attending Physician: The law requires to after death at the this certificate has been sinned biractor. Attentials certificate has been sinned.	ie funeral dir		To res 2000 To Inpatient 2002-Proutpatient 30 Do	JA 4   Nursing Home		ce 6 Other (Specify) v injury occurred
	Divis Jor Atte	I in by th	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factor building, etc. (Specify)	y, office 28f.	. Location (Stre City or Town,	eet and Number or Rural Route Number, State)
	a Hospita 24 hours	completely filled in by the	edical	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, death occurred 2 Medical Exeminer: On the basis of examination and/or investigation and manner stated.	at the time, date and place, and i, in my opinion, death occurred	d due to the cau at the time, date	ise(s) and manner as stated. e and place, and due to the cause(s)
	To the within	compl	Me	29b. Signature and title of certifier 29c	c. License number		d. Date signed (Month, Day, Year)
	,			30. Name and address of person who completed cause of death (Item 23a) (Type Print)	d Dr Easton	,,,	
	:□ R	State egistra	20.0	31. Date filed (Month, Day, Year)  NOV 3 0 2004  As A A A A			1

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of He rtificate of D	alth and Meath		ene2 () ()	4 39081
	Physici /Medic		1. Decedent's Name (First, Middle, Las MARIAN C. V.	t) ERNON				2. Date of Death Month NOVEMB	ER20,20	3. Time of Death 8:30 P.M
	Examir		4a. Fecility Name (If not institution, give Laurel Regional			4b. City, Town, or L Laure			4c. County of D Prince	George's
	Funeral Director		5. Social Security Number 6. S 555-44-7161	7. Ag	ge (In yrs. last birthday 95 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan, 24,	1909 t	Birthplace (State or Foreign Country) Jtan
	yland		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	the Mar 28a-f s	Director	Florida Sarasot	a	Sarasota	10f. Zip Code		10	g. Citizen of What	1 ☐ Yes 2 No
	23a or	ral Di	1512 Pelican Cove	Road, GR	139	34231			United St	•
036	urs after des al', or Itams Examinar m	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces: 1  Yes 2  If Yes, Give Year or Dates:		Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 No	panic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		merican Indian, thite, etc. White
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or Items 23s or 28s-f show aumatic event, Its Medical Examinat marke a colified at	Completed by	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		(Give	dent's Usual Occupation of work done during DO NOT use retired)	ring most of worki	ing	6b. Kind of Busine	ss/Industry
land 2	illed Hygi other	To Be Co	17. Father's Name (First, Middle, Last) Adelbert Little	Clawson			8. Mother's Name	e (First, Middle, M Ann Rob	laiden Sumame) erts	
Mary	nd 2 shortlith and h		19a. Informant's Name/Relationship ( Kay J. Dillon –Da	ype, Print) ughter	19b. Mail 1133	ing Address (Street and 7 Frances I	Number or Rura Drive Be.	l Route Number, Ltsville	City or Town State Marylar	nd 20705
Baltimore,	permit. Pages 1 and 2 should by Oberaturent of Health and Menta Important: If item 27 is marked any injuryen other traumatic and one.		20a. Method of Disposition  1 X Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify		20b. Place of Disp cemetery, cre Sarasota	osition (Name of matory or other place) Memorial I	i i		oc. Location - City Sarasota,	
Balt	permit. Departi Import. any inj		21. Signature J. F. Fral Service Licen	anto	7 DX	2. Name and Address Onald V. Bo 400 Powder	of Facility Drgwardt Mill Roa	Funeral ad Belts	Home, P. ville, Ma	A. aryland 20705
	Physician /Medical	000	23a. Part 1. Enter the disease, or com, shock, or near failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Stroke	d the death. Do not en					Approximate Interval Between Onset and Death
Ş	Examiner		Sequentially list conditions	Conges	a consequence of): tive Heart	Failure				
_^	icate be executed physician and the burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	a consequence of):					
98760	physicial physicial the buri	dlcai		d				<del></del>	<u></u>	
O. Box 6	law requires that the death certifi as been signed by the attending i 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of o	delivery Day Year
rds, P.	w requires that the bound by should be detach	by	Part II. Other significant conditions of Dysphagia	entributing to death b	out not resulting in the u	inderlying cause given	in Part I.			to the cause of death?  Probably 4 □Unknown
al Kecords,	The ate h page	Completed						24a. Was an autopsy perform	prior t ed? death	autopsy findings available o completion of cause of ?
Vital	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☑ Inpatio	ent 2 ☐ ER/Outpatie	Other	1000	(Check only one	) ice 6	
lon of		-1	27. Manner of Death  1 XNatural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	iry 28b. Time o	f 28c. Injury at Work?	The same of the sa	28d. Describe how		oecny)
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	286. Flace of In	ury - At home, farm, st c. (Specify)	reet, factory, office	3	28f. Location (Stre City or Town,	eet and Number or State)	Rural Route Number,
	To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by	edical	29a. Certifier 1 X Certifying Ph (Check only 2 Medical Examone)	vsician: To the best iner: On the basis o and manner st	of my knowledge, deat f examination and/or in ated.	h occurred at the time, vestigation, in my opin	date and place, a ion, death occurre	and due to the cau ed at the time, dat	ise(s) and manner e and place, and d	as stated. ue to the cause(s)
	To within	Ň	29b. Signature and title of certifier	1 He	ree	29c. License n	323		d. Date signed (Mo	ogth, Day, Year)
	(0		30. Name and address of pers A mood Darryl Hill, M.D.	ompleted cause of a	leath (Item 23a) (Type, 1timore Ave	Print)				
	Sta Registr	_	31. Date filed (Month, Day, Year) NOV 2 3 20	32. Registr	ar's Signature	Ann. V. 1	-			

			For State Registrar		yland / Depa		Health and	Mental Hygie	•	39082
	Physici /Medic Examin	al	Decedent's Name (First, Middle, Las     Edward Richard     4a. Facility Name (If not institution, give     Suburban Hospital	Venit			or Location of Dea	2. Date of Death Month November	Day Year	3. Time of Death 5:15 A M
	Funeral Director		5. Social Security Number 6. Se	7. Age (	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days			ear) 9. Bi	rthplace (State or Foreign country) hington D.C.
	hours after death with the Maryland tural', or items 23a or 28a-f show a Exactical must be ruillised at	Funeral Director	10a. State 10b. County  MD Montgome  10e. Street and Number  9515 Kingsley Av	ry	0c. City, Town or Lo	thesda 10f. Zip Code	4-1636		. Citizen of What C	
0036	be filed within 72 hours after death with the Marylan Hygione. d other than "natural", or items 23a or 28a-f show event, the Madical Examination must be nutified at	Ď	11. Marital Status  1 ☐ Never Married 2 ☒ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 Moo If Yes, Give Year or Dates:		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 💢 No	lispanic Origin? ( an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh Specify: W	erican Indian, ite, etc. hite
-61212	filed within 72 Hygiene. Ither than "nal	• Completed	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12)	de completed) College (1-4or 5+) 5+	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wo	me (First, Middle, Ma	Securiti	
Maryland	should and Men is marke	To Be	Edward Valentine  19a. Informant's Name/Relationship (7)  Nan G. Venit / Wi	Venit Type, Print)	6		Joan L	ida Ashmar Oural Route Number, C Bethesda	l City or Town, State,	
αĵ	permit. Pages 1 and 2 Department of Health importent: If item 27 any injury or other tra		20a. Method of Disposition  1 □ Burial 2 ☒ Cremation 3 □  4 □ Donation 5 □ Other (Specify  21. Signature of Funeral Service Lie in	Removal from State  ) see	20b. Place of Dispo cometery, cre Metropol Crer	osition (Name of matory or other pla Ltan natory 2. Name and Addre	Nove	mber 26 Al 004 Europe	c.Location-City o Lexandia, neral Hom	rTown, State Virginia e, 10 East
760,	Physician /Medical Examiner is prujal-itansit	cal Examiner	23a. Part1. Enter the disease, or companies, or hear failure. List only of the companies of	blications that caused the cause on each line a	ne death. Do not en		ng, such as cardia			Approximate Interval Between Onset and Death
O. Box 68	The iaw requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal death 3	□Ectopic pregnanc	у		23d. Date of de Month	olivery Day Year
Records, P.	w requires that the debeen signed by the a	by	Part II. Other significant conditions of		_		ven in Part I.	23e. Did tobac	h	to the cause of death?  Probably 4 □Unknown
Vital Rec	sicien: The law a certificate has be irector, page 2 sh	e Completed	25. Was case referred to medical				26 Place of De	24a. Was an autopsy performe 1 Yes 2	prior to	
Division of Vil	ding Phy I. After this funeral o	atlon; To Be	examiner? 1		28b. Time o	of 28c. Inju	her: 4 Nursing	Home 5 Residence 28d. Describe how		ecity)
Divis	itel or Attending after death rai Director: led in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc.	y - At home, farm, st (Specify)	reet, factory, office		28f. Location (Stree City or Town,		iural Route Number,
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	Medical		ysician: To the best of niner: On the basis of e and manner state	xamination and/or in		opinion, death occ	urred at the time, date		e to the cause(s)
			> Breura	Perju, MC	oth (ltors 22a) (Time				•	
			Brent A. Benger, M.  31. Date filed (Month, Date Year)	10215 Fe	unwood Rd	1. Suite	100, Beth	No esda, Manylo	ind 20817	
	Sta Regist			304 Since	me B	Spork	21			

			For State	State of Ma	ryland / Depa	artment of H		ental Hygie	ene .2001	30083
	•	Æ.	Registrar  1. Decedent's Name (First, Midd	le, Last)		inicate of E	Joan	2. Date of Death	I NO U U I	3. Time of Death
	Physicia /Medic		Larry	Hamilton	Wood			Nov. 20	Day Year 2004	7:35 А м
	Examin	er	4a. Facility Name (If not institution  Southern Mary		Conton	4b. City, Town, or Clintor	Location of Death		4c. County of Dea	
	Funeral		5. Social Security Number	6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y		George 'S thplace (State or Foreign
	Director		219-48-3174 Usual Residence of Decedent	1 M 2 F	56 Yrs.	Nontro Days	110010	Jan. 8,		shington, DC
	ryland how		10a. State 10b. County	,	10c. City, Town or Lo	ocation				10d. Inside City Limits
	he Ma	ector		rles	Bryantov					1 ☐ Yes 2 No
	3e or 3	I Dir	10e. Street and Number 13730 Edelen I	)rive		10f. Zip Code 20617		100	J. Citizen of What Co	ountry?
	death	nera	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spe	cify Yes or No-	14. Race - Ame	
36	72 hours after death with the Maryland naturel', or Items 23e or 28a-f show disal Enar it we must be profiffed at	by Funeral Director	1 ☐ Never Married 2 ☐ Mai 3 ☐ Widowed 4 【※Divorces	ried 1 Yes 2 N	lo l		Specify:	noan, ott.)	Black, Whit	e, etc.
9	2 hour	ted b	15. Deceder	nt's Education	16a. Dece	dent's Usual Occupa	tion	16	b. Kind of Business	ite /Industry
215	within 7 ene. than "n	Completed	(Specify only higher Elementary/Secondary (0-12)	college (1-4or 5	+) life.	kind of work done d DO NOT use retired)	)	ng		
421	filed w Hygier other th	Col	9 17. Father's Name (First, Middle,	Last)	Pre	esident/Ow	INEY 18. Mother's Name	(First, Middle, Ma	Contracti	ng
Maryland 21215-0036		To Be	Ashby Hamilt					ra Underw		
Aary	2 should be and Mental Is marked (		19a. Informant's Name/Relation						City or Town, State, J	
	s 1 and if Health Item 27 othar tr		Kathryn L. Pra 20a. Method of Disposition	ther - Flance		Edelen Edelen Education (Name of matory or other place			MD 20617 c. Location - City or	
E O	Pages ent of nt: If If		1 Burial 2 Cremation 4 Donation 5 Other (	3 ☐Removal from State Specify)					onardtown	
Baltimore,	permit. Pages. Department of H Importent: If Ite eny injury or of		21. Signature of Funeral Service	Licensee M00	OF 3	Name and Addres Huntt Fun P.O. Box	s of Facility		20604	,
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that caused t only one cause on each lin	the death. Do not ent					Approximate Interval Between
	Prrysician /Medical		Immediate Cause (Final disease or condition resulting in death)			RACEREB	RAL BL	EFD.		Onset and Death
ş	Examiner			Due to (or as a	a consequence of):					
	P ≅	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Unionlying	b. Due to (or as a	a consequence of):					-
	and -trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	a consequence of):					
8760,	death certificate be executed e attending physician and id for use as the burial-transit	dicalE		d						:
9	ntificat ng phy e as th	Medi	IF FEMALE:						1	
Вох	death certifica attending ph d for use as t	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of the state of the st	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
P.0.	that the de ed by the detached	by Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	ume or death 5					
	S C 0		Part II. Other significant conditi	ons contributing to death bu		nderlying cause give	n in Part I.			the cause of death?
Division of Vital Records	aw Is b	Completed		HYPER	TENSION			24a. Was an autopsy	24b. Were au	stopsy findings available completion of cause of
E E	The ate h page							performe	d? death?	2 No
Vit.	Physicien: Th this certificate ral director, paç	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ♣ No	Hospital:	nt 2 ER/Outpatier	othe Othe	26. Place of Death		ce 6 Other (Spe	o(f.)
n of	iding Phys th. : After this funeral dir	on; To	27. Manner of Death  1 Natural 5 Pendi	28a. Date of Injur	y 28b. Time o		at 2	28d. Describe how		cny)
Sio	Attending ir death. actor: After by the fune	catle		igation at he			es 2□No	104 Lanation (Cam-	- A A /	The Alexander
Div	spitel or Attendours after death ours after death neral Diractor: filled in by the	Certification;	4 Homicide determination	building, etc	rry - At home, farm, str (Specify)	eet, factory, office	4	City or Town,	et and Number or Ru State)	arai Houte Number,
	Ho.	edical C	29a. Certifier 1 Certifyi (Check only one) 2 Medical	ng Physician: To the best of Examiner: On the basis of and manner sta	examination and/or in	h occurred at the tim vestigation, in my op	e, date and place, a inion, death occurre	and due to the caused at the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certific	Amquel		29c. License			. Date signed (Monta	h, Day, Year)
•			30. Name and address of persor	/	agth (Itam 33a) (To		57928		11/20/04	
1	19641		M ASOCO A NW AR	- 1328 So	when Aue	, SE #21	4 WK	HINGTON	DC 200	032
	Sta Registr		31. Date filed (Month, Day, Year NOV 2	3 2004 32. Reg tra	r's Signature	Sperke				

			For State Registrar		State o	f Marylan		artmen rtificate			and M		giene ()	04	390	84
П	Physici		1. Decedent's Name	(First, Middle, La: Wilson	st)					-		2. Date of De Month NOV -	1 Day	2 0 0	3. Time of 4 12:2	
	/Medi Examir		4a. Facility Name (If		e street and nur	mber)		4b. City,	Town, or	Location of	of Death			inty of Deat		.op
	Funeral Director		Anne An 5. Social Security No 578-54-4 Usual Residence of	umber 6. S 1268	Medica ex □м 2ॉ1 F	l Cent 7. Age (In yrs. 92		If Under Months		Id Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da Mar. 1,	th y, Year)		rundel hplace (State d untry) Germai	or Foreign
	aryland show det	_	10a. State	10b. County Anne Ar	undel	10c. Cit	y, Town or Lo		orna	Park					10d. Inside Ci	•
	28a-f	recto	10e. Street and Num		uraer			10f. Zip		ralı			10g. Citizen	of What Co	1 ☐ Yes untry?	2 <b>X</b> NO
	ath with	ral Di	316 St.	Bees Dri					211					ermany	Y	
215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, The Medicial Exams as installed indiffed at	Completed by Funeral Director	11. Marital Status 1 □ Never Marrid 3 🌁 Widowed	ed 2 Married 4 Divorced	12. Was Dece Armed Fo 1Yes If Yes, Giv Year or D	2 📉 No 'e		Was Deced if Yes, spec 1 Pes 2		spanic Origin, Mexican Specify:	gin? (Spe n, Puerto	ecify Yes or No Rican, etc.)		Black, White	ncan Indian, e, etc. White	
15-(	in 72 h n "natu ledlen	plete		15. Decedent's Edify only highest gra	ide completed)	45-)	16a. Deced (Give life. I	dent's Usua kind of wor DO NOT us	l Occupa k done d e retired)	tion uring most	t of worki	ing	16b. Kind o	f Business/I	Industry	
2	filed within Hygiene. Ither than "	Com	Elementary/Secon		College (1 +5	-40r 5+)	We We	omen':							Lothro	p
land	ould be fil Mental H arked otl	To Be	17. Father's Name (								er's Name Ly Bl	(First, Middle, . <b>um</b>	Maiden Sun	name)		
Maryland	and 2 should salth and Men n 27 is marke ier traumatic		19a. Informant's Na Monica	me/Relationship ( Brown/Dat				•	•			I Route Numbe Severna			ip Code) 21146	
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr oncs.			osition Cremation 3  5 Other (Specify		State	Place of Dispo cemetery, cren Metro	natory or ot	her place			20, 2004	20c. Location Baltin			
Balti	pernit. Pa Dep. rtmen Imp. rtant: any injury once.		21. Signature of Fu	///	1500	all	) B	Name and arrand	d Address	s of Facility Sons	P.	A. Seve	erna Pa	ark Fu	meral D 211	Home
	Physician /Medical Examiner		Immediate Cause ( disease or condition resulting in death)		plic yons that one cause on e	gestu	h. o not ent					or respiratory ar			Approximate Interval Bette Onset and I	e ween
,09289	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list cor if any, leading to im- cause. Enter Under Cause (Disease or that initiated events resulting in death) L		c. Due to (	or as consequence or as conseq	uence of): uence of):	lar	Try	arej	Cen	+			dan	z
O. Box 6	that the death certifica ed by the attending ph detached for use as th	Physiclan/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?		irth 2 Feta ant at time of d	Ideath 3	Ectopic pre Other (spe		2209115				Date of delive Month	,	/ear
rds, P	quires that the signed by ald be detacted	by	Part II. Other signifi	cant conditions c	ontributing to de	eath but not res	ulting in the ur	nderlying ca	tuse give	n in Part I.		23e. Did to	_/		the cause of d	
	The law requir cate has been s page 2 should	Completed	L											b. Were aut prior to co death? 1 \( \sum \text{Yes}	opsy findings a completion of ca	available ause of
Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referr examiner?	ed to medical	Hospital:	npatient 2	ER/Outpatien	t 3 🗆 DO	Othe	-		(Check only o		Dub (0	'A.1	
	Jing After fune	$\vdash$	27. Mann f Death 1 atural 2 Accident		28a. Date of (Mont		28b. Time of Injury		3c. Injury Work		2	ne 5 Resid			ny)	
Division		Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	289. Place	of Injury - At hong, etc. (Specif)	ome, farm, stre	et, factory,	office		2	28f. Location (5 City or Tow		mber or Rur	ral Route Numi	ber,
	To the Hospital or within 24 hours afte To the Funeral Dir completely lilled in	edical (	29a. Certifier (Check only one)	1 Certifying Ph 2 Medical Exan	ysician: To the niner: On the ba and mann	isis of examina	wledge, death tion and/or inv	occurred a restigation,	at the time in my opi	e, date and inion, deat	d place, a	and due to the dead at the time, d	ause(s) and date and plac	manner as	stated. to the cause(s)	)
		N	29b. Signature and	title of certifier	) .	n			License	number	1		29d. Date/sig	ned (Month,	Day, Year)	
	A Sec.		30. Name and addre	ess of payson who	completed caus	e of death (Item	n 23a) (Type, I		/ \	511	/		171	1/0	7	
			Harry Day	ris, MD			2001		al P	arkwa	ay	Annapo	olis, N	MD 214	101	
	Sta Registr		31. Date filed (Mont	NOV 22		gistrar's Signa		book	,							

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryla		nent of Health an	d Mental H	4004	39085
	Physic		1. Decedent's Name (First, Middle, Las	T PASE	A P X I	1551	2. Date of D	Reg. No.	3. Time of Deanh
	/Med Exami		4a. Facility Name (If not institution, give	street and number)	4b. (	City, Town, or Location of D	eath	4c. County of Deeth	4.0 /1 · ™
	Funera Director	_	V-1 10 1200	De Ct. He ex M 2/1 F 7. Age (In you	ot T4 s. last birthday) If U Mon Mon	nder 1 Year II Under 24 Iths Days Hours M	Frs. 8. Date of B	Birth Day, Ygar)  9. Birth Cou	plece (State or Foreign
	show		Usual Residence of Decedent  10a. State 10b. County	10c. (	City, Town or Location				10d. Inside City Limits
S	the Ma	recto	MD Harto	Rd	De 1	Cany		10g. Citizen of What Cou	1 ☐ Yes 2 No.
U 25	1036  ours after death with the Ma s  rai, or itema 23a or 28a-f shor  Eran is not must be notified at	Funeral Director	1307 Linope  11. Marital Status	Cd. Apt 7 12. Was Decedent Ever in	74	2 1017 ecedent of Hispanic Origin? specify Cuban, Mexican, Po	(Specify Yes or N	USH	
AKD	1215-0036 within 72 hours after death with the Manne. sne than "netural", or itema 23a or 28a-1 a Medical Erar, a nermast to mutiliso	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1  Yes 2  No If Yes, Give Year or Dates:	II Yes, 1 ☐ Ye	specify Cuban, Mexican, Pu es 212 No Specify:	uerto Rican, etc.)	Specify: W	hite
4 22	re, Maryland 21215-00; s 1 and 2 should be filed within 72 hours I Health and Mental Hygiene item 27 is marked other than "netural; other traumatic event, tra Medical Exp	Completed	15. Decedent's Ed (Specify only highest grader) Elementary/Secondary (0-12)		1 14114	f work done during most of T use retired)	working	16b. Kind of Business/Ir	DOUTAL
Ros	ind 2: be filed v tat Hygie d othert	Be Co	17. Father's Name (First, Middle, Last)	7	TEACH		Name (First, Middle	MCDITATION (Maiden Sumame)	rion .
1 -	Maryland 2. 12 should be filed v h and Mentai Hygie r is marked other t r is marked.	ToE	John H 19a. Informant's Name/Relationship (7	ROUSSI	10h Mailine Add	Eth	el M.	Wilkens	
argares	and 2 s leath an m 27 is n		Cynthia Yock	ey	1307 L	iriope Ct.	Ap+T4	ber, City or Town, State, Zi	o Code) O MO 21017
ob	Pages 1 arennent of Heam		20a Method of Disposition  1 Burial 2 Cremation 3   4 Donation 5 Other (Specify	Removal from State	Place of Disposition (cemetery, crematory	(Name of or alber place)	Date _ S A/	20c. Location - City or	own, State
હ	Baltimore, permit. Pages 1 a Department of Hes Important: If item any injury or othe once.		21. Signature of Funeral Service Licent		AND FUNE	e and Address of Facility		Forest H imonium me	
_	40260		23a. Part 1. Enter the disease, or comp	lication that caused the dea	ath Do not enter the r	FULLITERN mode of dying, such as card	ATIVES F	FUNTRALE C	Approximate
	Physician		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a	20/10-10	and an an	م نی	A	Onset and Death
md	Medical icate be executed by physician and supervision and sup	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conse	Alambe equence of):	in/D	obeles	mo Clitus	year
37	he ate	Aedical	IF FEMALE	d					
1 9:3	Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending pl completely filled in by the funeral director, page 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	tal death 3 □Ectopi	c pregnancy (specify)		23d. Date of delive Month	ery Day Year
12/2	ds, Puires that signed b	b	Part II. Other significent conditions co	ntributing to death but not re	sulting in the underlyin	ng cause given in Part I.		tobacco use contribute to the	
	ecor law req as beer	Completed	The state of the s		<del></del>		24a. Was		psy findings available
	ral R n: The fficate h or, page		25. Was case relerred to medical				1 ☐ Yes	ormed? death? 2 1 No 1 Yes	
	oysicia nysicia nis cert direct	To Be	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	☐ER/Outpatient 3☐	04	Home 5 TResi	gee) idence 6 □Other (Specif	v)
	OD O		27. Manner of Death  1 Privatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		how injury occurred	,
	Division of Vital Records, tal or Attending Physician: The law requires t is after death.  al Director: After this certificate has been signed in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, street, lac		281. Location ( City or To	(Street and Number or Rura wn, State)	l Route Number,
	e Hospi 24 hou e Funer etely fill	edical	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my kn ner: On the basis of examin- and manner stated.	owledge, death occurr ation and/or investigat	red at the time, date and plation, in my opinion, death oc	ce, and due to the curred at the time,	cause(s) and manner as si date and place, and due to	ated. the cause(s)
	To the within To the complete	Me	29b. Signature and title of certifier			29c. License number		29d. Date signed (Month,	Day, Year)
	<i>(</i> )		30. Name and address of derson who co	empleted cause of death liter	m 23a) (Type Print)	nD D003	1,028 [		8,2004
	2		CRAIG M. Show	ghnessy wil	2 104 PI	untree K	d. Belo	Air IND	
	Sta Regist	ate rar		32. Registrar's Sign	ature &	Spark			

		-	ror		Department of Health a		211111 30106
	٥,		Hegistra M. Name (First Middle Last)		338 "12/46/64" 3	2. Date of Death	3. Time of Death
	Physici /Medic	al		urgess	4h Cib. Town and applied	11 30	0 2004 d0x6 M
1	Examin	er	4a. Facility Name (If not institution, give s	HKY LAND	4b. City, Town, or Location of Baltinion		4c. County of Death Balhnore
	Funeral Director		5. Social Security Number 6. Sex 212-69-4713	M 20 F 7. Age (In yrs. last bit	hthday) If Under 1 Year If Under Yrs. Months Days Hours	24 Hrs. Min.  8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign
	land		Usual Residence of Decedent  10a. State 10b. County	10c. City, Tow	n or Location		10d. Inside City Limits
	a-f she	ctor	MD N/A		Baltimore		1 <b>XX</b> ves 2 □ No
	th with the 23e or 28 ast by my	Funeral Director	10e. Street and Number 1837 Covington St	reet	10f. Zip Code 21230	10g.	Citizen of What Country? USA
215-0036	s 1 and 2 should be filled within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "naturel", or flems 23e or 28e-f show other traumatic event, the Madical Expressed must be indiffied at	by	11. Marital Status 1  ***Mever Married 2   Married 3   Widowed 4   Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1	13. Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexicar 1  Yes 2 No Specify:	gin? (Specify Yes or No- i, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
5-0	"natur	letec	15. Decedent's Educ (Specify only highest grade	ation 16a completed)	. Decedent's Usual Occupation (Give kind of work done during mos life. DO NOT use retired)	t of working	. Kind of Business/Industry
212	d within giene. or then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	N/A		N/A
Maryland	2 should be filad within 7 and Mental Hygiene. r is markad other then "r raumatic event, the Mental	To Be C	17. Father's Name (First, Middle, Last) Willard A. Burges	ss, Jr.		or's Name <i>(First, Middle, Maid</i> Onda Daniel	den Sumame)
	ind 2 shoi alth and N 27 is ma or traums		19a. Informant's Name/Relationship (Type Willard A. Burgess		o. Mailing Address (Street and Number 37 Covington Street		
Baltimore,	o = to		20a. Method of Disposition 1 ★Burial 2 □ Cremation 3 □ Ro 14 □ Donation 5 □ Other (Specify)	amoval from State 20b. Place o comete Meado	f Disposition (Name of ry, crematory or other place) wridge Cem. Dec		Location - City or Town, State Baltimore, MD
Balt	permit. Pa Departmen important: any injury once.		21. Signature of Funeral Service License	Victor P. Doda, Jr	• 22. Name and Address of Facility Charles L. Stevens 1501 Fast Fort Ave		
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	e cause on each line.		cardiac or respiratory arrest,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence	aurest	1 /	/
ľ	Examiner		Sequentially list conditions.	Underlyin	& Conseritor	l heart d	iseare
1.	tad nsit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a convequence)	91:		
68760,	ficate be executad physician and s the burial-transit	edical Examiner	that initiated events cresulting in death) Last	Due to (or as a consequence	of):		
	rtificate be ng physicia as the bur		IF FEMALE:				
O. Box	he death certiff the attending ched for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
rds, P.O.	requires that the d een signed by the rould be detached	by	Part II. Other significant conditions con	tributing to death but not resulting i	n the underlying cause given in Part I		co use contribute to the cause of death? 2 No 3 Probably 4 Unknown
of Vital Records,	has by	Completed				24a. Was an autopsy performed 1 Yes 2	24b. Were autopsy findings available prior to completion of cause of death?  No 1   Yes 2   No
Vita	Physician: The this certificate ral director, page	Be	25. Was case referred to medical examiner?	ospital:	Other	of Death (Check only one)	
of	N S	1: To	Yes 2 No ☐	28a. Date of Injury 28b.	Time of 28c. Injury at	rsing Home 5 Residence 28d. Describe how in	
ion		ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury Work?  M 1 Yes 2	No	
Division	tal or Atta	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, late)
	To the Hospital or Attend within 24 hours after death To the Funerel Director: A completely filled in by the f	edical (	29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Examination	ician: To the best of my knowledg er: On the basis of examination ar and manner stated.	e, death occurred at the time, date an nd/or investigation, in my opinion, dea	d place, and due to the cause th occurred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To th To th	Ň	29b. Signature and title of certifier	Tesional	29c. License number	29d.	Date signed (Month, Day, Year)
			30. Name and address of person who co	,	(Type Print)	16 1	7 30107
	9		GETACIEU	TESHONE	M.D. 225000	of Geenst.	DAHMO
•	Sta Regist	_	31. Date filed (Month, Day, Year) DEC 1 0 2004	32. Registrar's Signature	Sports		

			1 - For State Registrar	State of M	1arylan		artment <i>tificate</i>					giene () (	) 4	390	87
	Physici	an	1. Decedent's Name (First, Middle, Last)								2. Date of De		Xear	3. Time of I	
	/Medio	al		nes			4 0: 7				Decembe			7:37	Рм
	Examir	ier	4a. Facility Name (If not institution, give s Gilchrist Center		")		Tows		Location of	of Death		4c. County Baltin			
	Funeral		5. Social Security Number 6. Sex		ge (In yrs.	last birthday)	If Under	1 Year		24 Hrs.	8. Date of Birt	h		place (State or	Foreign
ш	Director		216-32-1924	M 201	89	Yrs.	Months	Days	Hours	Min.	Jan 2	8, 1915	Mar	y and	
	pu .		Usual Residence of Decedent  10a. State 10b. County		100 Cit	v. Town or Lo	cation							10d. Inside Cit	a I feedan
	Aaryla f sho	ō	Md. Howard			umbia	odtion							1 □Yes	
	28a-	Director	10e. Street and Number				10f. Zip	Code				10g. Citizen of	What Cou	ntry?	
	th with		8306 Painted Rock	Rd.				2104	5			1	USA		
	ams ams	Funeral	11, Marital Status	2. Was Deceden Armed Forces	t Ever in U.	.S. 13. \	Was Decede	ent of His	spanic Ori	gin? (Spe	cify Yes or No- Rican, etc.)	- 14. Rad	e - Ameri	can Indian,	
36	s afte	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2X If Yes, Give	] No	1	I □ Yes 2				, ,	Specif		ite	
0	d within 72 hours after death with the Maryland jiene. r than "natural", or Itams 23a or 28a-1 show the Medical Examinat must be notified at		15. Decedent's Educ	Year or Dates		16a Deced	lent's Usual	Occupa	ition	-		16b. Kind of B			
215	within 72 ene. than "na re Medic	piet	(Specify only highest grade Elementary/Secondary (0-12)		541	(Give	kind of work DO NOT use	k done d	urina mosi	t of worki	ng			330.17	
21		Completed	10			Homem	aker					Own H	ome		
pu	a d o d o	Be	17. Father's Name (First, Middle, Last)  Joseph S. DeFonte:	•						r's Name i 1da	(First, Middle, Enis	Maiden Suman	10)		
Maryland 21215-0036	s 1 and 2 should be f f Health and Mental I itam 27 is marked o othar traumatic ava	To	19a. Informant's Name/Relationship (Typ			10h Mailin	a Address	/Street a				er, City or Town,	State 7	Codo	
Ma	nd 2 sho lith and 27 is m		Mrs. Carol Burnham	/ Daught	er		-					bia, Md			
ē,	is 1 and 2 of Health a item 27 is other trae		20a. Method of Disposition		1 ~	lace of Dispo	sition (Nam	e of	- 1		ate	20c. Location			
			1 XBurial 2 ☐ Cremation 3 ☐ R `4 ☐ Donation 5 ☐ Other (Specify)	emoval from Stat		aney V				12-11	L-04	Timon	ium,	Md.	
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service License	3		22	Ruck 1050	LAddres TOWS York	on Fu On Fu Rd.	inera Tows	1 Home	Inc. 21204			
			23a. Part1. Enter the disease or complications shock, or heart failure. List only on	nons that cause e cause on each	ed the death	h. Do not ente	er the mode	of dying	, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Betw	reen
	Pnysician		Immediate Cause (Final disease or condition	Str	Nie									Onset and Do	eath >
	/Medical Examiner		resulting in death)	Due to (or a	s a conseq	uence of):									
		-	Sequentially list conditions,	Due to (or a	s a consequ	uence of):							-	_	
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Chiesas of Figury	200 10 (0. 0	o a oonooq.	30,100 01).									
o,	be executed sician and burial-transit	Еха	that initiated events c resulting in death) Last	Due to (or a	s a consequ	uence of):									
8760,	o y	edicai	d												
9	artifica ing ph e as t	Med	IF FEMALE:					-							
Вох	death certifica attending ph	Physician/M	23b. Was decedent pregnant in the past 19 months?	3c. If yes, outcom	2 Feta	death 3	Ectopic pre						te of delive inth		ear :
Ö	e the	ysic	1 Yes 2 NNo 9 Unknown	4□Pregnant 9□Unknown	at time of di	eath 5L	Other (spe	спу)							
Ф.	s that the	by Ph	Part II. Other significant conditions con	tributing to death	but not resi	ulting in the ur	nderlying ca	use give	n in Part I.		23e. Did to	bacco use cont	ribute to ti	ne cause of de	ath?
rds	w requires that been signed b should be deta							_			1 □ Y	es 2 X No	3 Prob	abiy 4 🗆 Ur	iknown
Vital Records,	aw is b	ompieted									24a. Was autop		Were auto	psy findings av	vailable
<u>m</u>	The ate h page	Сош									perfor	rmed?	death?	2□ No	250 01
/ita	Physiclan: T this certificat al director, pa	Be	25. Was case referred to medical examiner?	ospital:				Othe		of Death	(Check only or	nb)		1 95	
of	S S	T.	1 Yes 2 No	28a. Date of In		ER/Outpatien 28b. Time of		othe	4 LINU		ne 5 Resid	lence 6 Xe th	er (Specif	n Mos 1	4
on	Attanding Ph r death. Setor: After the oy the funeral	tion	1 Natural 5 Pending 2 Accident investigation	(Month, D	ay Year)	Injury	м	Work	?ົ ′es 2.⊟1		.oc. peschoon	ion injury specuri	80		
Division	I or Attandi after death. Director: A in by the fu	ertification;	3 Suicide 6 Could not be determined	28e. Place of Ir	njury - At ho	ome, farm, stre	et, factory,	office		2	28f. Location (S	Street and Numb	er or Rura	I Route Numbe	er,
۵	tal or A s after al Direct	Cert	4 □ Hollicide	bullaing, e	etc. (Specify	<b>(</b> )					City or Tow	m, State)			
	To tha Hospital or At within 24 hours after of To tha Funaral Directompletely filled in by	edical	29a. Certifier (Check only one)  Check only one)	ician: To the bes er: On the basis and manners	of examinat	wledge, death tion and/or inv	occurred a restigation, i	t the time in my op	e, date and inion, deat	d place, a th occurre	and due to the ded at the time, o	cause(s) and ma date and place,	nner as s and due to	tated. the cause(s)	
	To tha within 2. To tha complet	Me	29b. Signature and title of certifier	4				License				29d. Date signe			
	۶.		Manan	ans	)		7	15	830	3	1	Decemb	er	1 1009	β.
10	TAP		30. Name and address of person who col	npleted cause of		23a) (Type, 1	Print) V-	Ch	arles	r St	- Bali	Decemb Thur	m9 6	21204	
	Sta Registr		31. Date filed (Month, Day, Year) DEC 1 0 2004	32 Regis	trar's Signa مرصور	ture	Son	KN							

Buches, I'my 148/84 757pm

	í	1 - For State of Maryland / De Registrar	-	tment of H		and M		iene 20	04	39088
Physicia	an	1. Decedent's Name (First, Middle, Last)  Victoria Kathleen Brown					2. Date of Dea Month Decembe	Day	Year	3. Time of Death 3:40 PM
/Medic Examin	al	4a. Fecility Name (If not institution, give street and number)		4b. City, Town, or	Location of	of Death	Decembe	4c. County		3.40 1
Examin	eı	Cherry Lane Nursing Home		Laurel				Prince	Geo	rge's
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	-//	If Under 1 Year Months Days	If Under: Hours	24 Hrs. Min.	8. Date of Birth (Month, Day March 3	Year) 1, 1960	9. Birth	plece (State or Foreign ntry) Iaryland
he Maryland 88a-f show	ector	MD Prince George's Riverda						0- 00		10d. Inside City Limits  1  Yes 2 No
with t	Dir	10e. Street and Number 5804 67th Avenue		10f. Zip Code 20737				0g. Citizen of W U.S.A		nuyr
hours after death	by Funeral Director	11. Marital Status  1 Never Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Amped Forces?  12. Was Decedent Ever in U.S. Amped Forces?  14. Was Decedent Ever in U.S. Amped Forces?  15. Was Decedent Ever in U.S. Amped Forces?  16. Was Decedent Ever in U.S. Amped Forces?  17. Was Decedent Ever in U.S. Amped Forces?  18. Was Decedent Ever in U.S. Amped Forces?  19. Was Decedent Ever in U.S. Amped Forces.  19. Was Decedent Ever in U.S. Amped Forces.  19. Was Decedent Ever in U.S. Amped Forces.  19. Was		as Decedent of His Yes, specify Cubar	spanic Orig n, Mexican Specify:	gin? (Spe n, Puerto l	cify Yes or No- Rican, etc.)		c, White,	
patitimore, Interview A 12.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Department of Health and Mental Hydiene. Department of Health and Mental Hydiene. Department of the Interview of the Interview Intervention of the	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	Give ki ife. DO	nt's Usual Occupa ind of work done d O NOT use retired) e Superv	luring most )	t of workii	ng	16b. Kind of Bu Washing Adventi	ton	,
yiding and be filed Mental Hygarked otheratic event,	To Be C	17. Father's Name (First, Middle, Last) Frank D. Mickey, III						Maiden Sumam		
d 2 sho d 2 sho th and th and 7 ls ma traum				Address (Street a						
other t		20a. Method of Disposition 20b. Place of D		Park Av tion (Name of atory or other place		the state of the state of	rel, Ma ate	ryland 20c. Location -	207 City or To	
Dallimore Demit. Pages 1 Department of He mportant: If iten iny injury or oth		'4 Donation 5 Other (Specify) Parklaw	n M	emorial	Pk. 1				le,	Maryland
permit permit Depart Import any in		21. Signature of Funeral Service in Insee  MO0160	31	Name and Address Nalason 3 Talbot	t Ave	enue	Laurel	, Maryl	and	20707
Pnysician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  A Metastatic Colo	on		g, such as	cardiac o	r respiratory arr	est,		Approximate Interval Between Onset and Death
ate be executed as a spician and he burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or mury that initiated events resulting in death) Last  b. Due to (or as a consequence of)  C. Due to (or as a consequence of)								
certificate be ex redig physician use as the burial	Icai	d								
death death e atter	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ⚠ Nnhown		Ectopic pregnancy Other (specify)				23d. Date Mon		ery Day Year
necords, F.O. The law requires that the tite has been signed by the bage 2 should be detache.	by	Part II. Other significant conditions contributing to death but not resulting in the	he und	derlying cause give	en in Part I.					he cause of death?
	Completed						24a. Was a autops perform	ned? d	ere autorior to co eath?	opsy findings available impletion of cause of 2XXIIIo
Or VICAL F Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2XXNo  Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp.	ationt	3□ DOA Othe			(Check only on	ence 6 □Othe	r (Snacii	(v)
ding h. After fune		27. Manner of Death  1XX Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)  28b. Tirr Inju	ne of	28c. Injury Work		2		ow injury occurre		y)
LIVISION ITAIN ITA	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specity)	n, stree	et, factory, office		2	28f. Location (St City or Town		r or Rura	al Route Number,
To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, compared to the desirable of the physician: To the best of my knowledge, compared to the desirable of the physician: To the best of my knowledge, compared to the desirable of the physician: To the best of my knowledge, compared to the desirable of the physician: To the best of my knowledge, compared to the physician: To the best of my knowledge, compared to the physician: To the best of my knowledge, compared to the physician: To the best of my knowledge, compared to the physician: To the best of my knowledge, compared to the physician: To the best of my knowledge, compared to the physician: To the best of my knowledge, compared to the physician: To the best of my knowledge, compared to the physician: To the best of my knowledge, compared to the physician: To the best of my knowledge, compared to the physician	death o	estigation, in my op	pinion, deal	d place, a th occurre	ed at the time, d	ause(s) and mar ate and place, a 9d. Date signed	nd due t	o the cause(s)
To vit		29b. Signature and vitle of the children and some state of the		DH3	35	5/		12/8/	04	
1511 Sta	te	30. Name and address of per in who completed cause of death (Item 23a) (T)  1 Per COKWARA G20  31. Date filed (Month, Day, Year)  32. Registrar's Signature	ype, Pi	Greenbe	elt	Rd	Sinte U	1-15, G	llege	PK MD 2014
Registr		DEC 1 0 2004 Baneura	9	Spark						

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		•	State of Maryland / Department	artment of Health and N rtificate of Death	Mental Hygier Reg. N	2004 391189
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	3. Time of Death
	Physicia		Mary Elinor Blair		Manage .	4 2004 11:39 PM
)	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	4c. County of Death
			St. Agnes Healthcare	Baltimore		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)
	Director		212-26-8646 1 N 2 F 74 Yrs.		MAR. 22, 1	.930 Maryland
	g a	-	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo	neation		10d. Inside City Limits
	sho	5	MD Baltimore			1⊠Yes 2□No
	he N	Director	10e. Street and Number	10f, Zip Code	100.0	Citizen of What Country?
	a or	급	2917 Georgetown Road	21230		JSA
	d within 72 hours after death with the Maryland Jiene. I the Medical Evaninat must be notified at The Medical Evaninat must be notified at	Funeral		Was Decedent of Hispanic Origin? (S)		14. Race - American Indian,
_	Iter d	ᇤ	Armed Forces?	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
0000 0000	hours after tural', or Ite	þ	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: white
	2 ho	ted	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work	libo.	Kind of Business/Industry
<u>0</u>	within 72 ene. than "na	ed (	Elementary/Secondary (0·12) College (1·4or 5+)	DO NOT use retired)	9	
7	filed within Hygiene. other then rent, the M	Completed		emaker		Own Home
and	be filled stal Hygi of other svent, I	Be (	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maide	en Sumame)
<u>x</u>		ပ	Anthony Lamp		Butler	
Nar	2 is si			ng Address (Street and Number or Ru		
	1 and Health em 27			Georgetown Road,		
aitimore,	ges 1 a t of Hea If item or othe		1X Burial 2   Cremation 3   Hemoval from State	osition (Name of matory or other place)	/T. (000 t	Location - City or Town, State
	tant:			ige ridite rain	7/2004 E	lkridge, MD
a n	permit. Pages. Department of H Important: If ite any injury or of		Gá	2. Name and Address of Facility ary L. Kaufman Fur 250 Washington Bly	eralHome@	Meadowridge MP, Inc.
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
	Pnysician-		Immediate Cause (Final disease or condition	ardial TAR	ration	Onset and Death
	/Medical		resulting in death)  a	iardial Infa 7i Contravesor		
	Examiner		Sequentially list conditions b. ATV CD SE V CD T	Ji Condiavese	Mar 912	ease years
	ש ש	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			/
	and trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last			
Š,	icate be executed physicien and s the burial-transit	û	Due to (or as a consequence or).			
09/8	cate phys the	dlcal	d			
٥ ×	the death certific y the attending p	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
X O D	atten for u	lan	in the past 12 months?	☐Ectopic pregnancy ☐ Other (specify)		Month Day Year
j	the d	iyslo	1 Yes 2 No 9 Unknown			
J.	that the de ned by the a detached f	P V	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
Hecords	puires n sign	d by			1 🗆 Yes	2 No 3 Probably 4 Unknown
<del>ပ</del>	w require s been sij s should b	lete			24a. Was an	24b. Were autopsy findings available
	sician: The law requires that certificate has been signed b rrector, page 2 should be deta	Completed			autopsy performed? 1  Yes 2 A	prior to completion of cause of death?  1 Yes 2 No
Vital		O	25. Was case referred to medical	26. Place of Dea	th (Check only one)	
	Physician: this certific ral director,	To B	examiner?  1   Yes   No   Hospital: 1   Inpatient 2   ER/Outpatien	nt 3 DOA Other: 4 Nursing H	ome 5 Residence	6 ☐Other (Specify)
101	ding Phys h. After this funeral dir		27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	f 28c. Injury at Work?	28d. Describe how in	jury occurred
<u>0</u>	tendir leath. tor: Af the fur	atlc	2 Accident investigation	M 1 □ Yes 2 □ No		
UIVISION	or Attender de Directe	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, sti building, etc. (Specify)	reet, factory, office	28f. Location (Street: City or Town, Sta	and Number or Rural Route Number, ate)
_	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	al Ce	29a. Certifier Certifying Physician: To the best of my knowledge, deat	h occurred at the time, date and place	and due to the cause	(s) and manner as stated.
	n 24 h	edical	(Check only 2 Medical Examiner: On the basis of examination and/or in one)	vestigation, in my opinion, death occu	rred at the time, date a	nd place, and due to the cause(s)
	To the within To the comple	ğ	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
	(1)		Afterding Physicia	D51853	De	cember 5, 2004
1	1/2/		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	- 10	Bathrore 21229
			31. Date filed (Month Par Year) a 32. Signature	O Caton AV	enve !	DALLWOLL CITTLE
	Sta Registr		31. Date filed (Montin PECY 1/) 0 2004 32. Agistrar's Signature	pertu		

State of Maryland / Department of Health and Mental Hygiere 0 0 4 39090 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Charles Benz, Jr. /Medical 2004 10:259 M Ecember 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris at Mercy Hospital Baltimore N/A 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 374 20 4945 1**X** M 2□ F Director 79 Illinois Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location in then "natural", or Itama 23a or 28a-f show the Modeal Examinar must be notified at 10d. Inside City Limits Directo Maryland Anne Arundel 1 ☐ Yes 2√ No Hanover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1302 Phil-mar Drive Funeral 210**7**6 U.S. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates: Black, White, etc. 1 Never Married 2 Married δ 1 ☐ Yes 2√☐ No Specify: Specify: White 3∑ Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7;
Department of Health and Mental Hygiene.
Important: If itam 27 la marked other than "ne any injury or other fraumatic event, I're M-dic 2006. Elementary/Secondary (0-12) College (1-4or 5+) 6th Brakeman CSX Railroad 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Charles Benz, Sr. ပ Edith (not available) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Marsh / daughter 1302 Phil-Mar Drive Hanover, Maryland 21076 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State ` 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 12/10/2004 Baltimore, Maryland 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway omerous Baltimore, Maryland 21225 23a. Part1. Enter the disease of cos shock, or heart failure. List only pplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final Privsician disease or condition resulting in death) MADRIC Crephalpads /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any leading to make a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dira to (ut as a consequence of): he law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peeu p∘ge 2 s 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No e has Division of Vital 1 Yes 2.0 No certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No After this 27. Manner of Death 28c. Injury at Work? Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Hospital or Attanding 1 Natural 5 Pending after death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours To the Funaral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of pertifier 2 29c. License number 29d. Date signed (Month, Day, Year) 140854 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sebera 301 31. Date filed (Month, Day, Year) -82. Registrar's Signature State Registrar DFC 1 0 2004

State of Maryland / Department of Health and Mental Hygiene For State Registrar 391191 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year James A. Boragno December 6, 2004 1556 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore City
If Under 1 Year | If Under 24 Hrs. University of Maryland Shock Trauma Center 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Min. 1 M 2 □ F Months Days Yrs Director 566-60-5826 61 1943 California 16. Usual Residence of Decedent with the Maryland 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "neturel", or items 23a or 28e-f show treumatic event, the Modical Examples must be notified at 1 TYes 2 K No Director Maryland Montgomery North Potomac 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 20878 11832 Quince Mill Drive United States Funerai death 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No Not If Yes, Give Year or Dates: Available Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Airport Food & Elementary/Secondary (0-12) College (1-4or 5+) Senior Vice President Beverage Concessions 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fill h and Mental H 7 Is marked oth Be Doris Flannagan Remo Boragno 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 sinent of Health an Diane D. Boragno/Wife 11832 Quince Mill Drive, N. Potomac, MD 20878 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State December 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. ö permit. Page Department of Importent: If any injury or once. rium, Inc. 11, 2004 Bethesda, Maryland
22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Rockville, Inc. 300 West Montgomery Avenue
Rockville, Maryland 20850-2805 \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature eral Service Lice se M00803 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Intracranial Hemorrhage & Edema /Medical Due to (or as a consequence of): Examiner Traumatic Brain Injury 9 Days Saquartiany list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner CERTIFICATIO burial-tran requires that the death certificate be execu Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy į in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) 4☐Pregnant at time of death the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Sepsis, Acute Renal Failure, Respiratory Failure 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 Yes 2X No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1X Yes 2 □ No this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 28d. Describe how injury occurred After □Natural 5 Pending investigation death. 1700P<sup>M</sup> 11/27/04 2 X Accident Fall from ladder. after death Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 11832 Quince Mill 4 Momicide Home 20878 Dr., N. Potomac, MD 1 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) - Southy AU4176435 December 9, 2004 30. Name and address of person who completed came of death (Item 23a) (Type, Print) Kimberly A. Peck, 22 South Greene Street, Baltimore, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar BEO 1 0 2004

DHMH 17 Rev 1/2001

			1- For State of Maryland / Registrer		artment rtificate				fental Hy	gier Reg	noi.	3	19092
	Physic		Decedent's Name (First, Middle, Last)     MARY LOUISE BROYLES		-				2. Date of D Month	eath	ay Y	ear /	3. Time of Death
	/Medi Examii		4a. Facility Name (If not institution, give street and number) STELLA MARIS AT MERCY		4b. City, 1 BALT		Location o	of Death	Dece		lc. County of	Oo4 Death	-124 b
	Funeral Director		5. Social Security Number 236-28-1565  Usual Residence of Decedent  6. Sex 1 M 2 M F 7. Age (In yrs. last bit 2 M F 82	irthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Bi (Month, D 07/04/	irth 192	2 9	Birthpl Count	ace (State or Foreign ry) WV
d 21215-0036 83 % Walter	28e-f show	Director	10a. State         10b. County         10c. City, Tow           MD         ANNE ARUNDEL         BROOKI           10e. Street and Number         10e. Street and Number		PARK								0d. Inside City Limits 1 ☐ Yes 2∑ No
2	123a or	ral Dir	104 CAMROSE AVENUE		10f. Zip (					10g. C	itizen of Wha	t Count	ry?
036	and of Mental Hygiene. The Administration of thems 23a or 28e-1 show marked other then "natural", or tems 23a or 28e-1 show matic event, the Madical Evaluation of thems.	by Funeral	11. Marital Status  1 Never Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		Vas Decede f Yes, speci I 🗆 Yes 2			gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	0-	14. Race Black, \ Specify: \[ \]	Vhite, e	tc.
21215-0036	iene. rthen "natu	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give i life. E	lent's Usual kind of work DO NOT use EMAKET	done di retired)	urina mast	of worki	ng		Kind of Busin	ess/Ind	ustry
<b>S</b> 3	ev ev	To Be Co	17. Father's Name (First, Middle, Last)  JOHN LOPEZ	HOH	ENAKEI				(First, Middle	, Maide	n Sumame)		
Maryla	8 8 B	-	19a. Informant's Name/Relationship (Type, Print)				nd Number	r or Rura	l Route Numb	er, City		tө, Zip (	Code)
altimore,	ont of Health nt: If item 27 y or other tr		20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ Removal from State 20b. Place of cemete	of Dispos ary, crem	sition (Name natory or oth	e of ner place	)	D	NNAPOL	20c. l	ocation - City		
Balti			21. Signature of Funeral Secreto Licensee	22.	Name and	Address	of Facility	SIN	GLETON LEN BUI	FUN		OME	, PA
	hysician		23a. Part 1. Enter the disease, or commentations that caused the death. Do shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition esulting in death)	not ente	r the mode	of dying	such as o	cardiac o	r respiratory a	rrest,		1	Approximate nterval Between Onset and Death
	Medical xaminer	er	Due to (or as a consequence										
ou, be executed	physician and s the burial-transit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence c. Due to (or as a consequence)	of):									
OS/	ohys the	Aedical	d										
. ug	he atter	hysiclan/M	23b. Was decedent pregrant in the past 12 months?  1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 9 Unknown		Ectopic preg Other <i>(spe</i> c						23d. Date of Month	,	ay Year
The law requires that the	s been signed by t should be detach	leted by Ph	Part II. Other significant conditions contributing to death but not resulting in	the und	derlying cau	ise given	in Part I.			obacco /es 2			cause of death?
	ate has	Comp							24a. Was autop perfor 1 Yes	sy	prior	o comp	y findings available letion of cause of
Ol VII.dl	.97 0	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No  Hospital: 1 ☐ Inpatient 2 ☐ EP/Ou	tpatient	3□ DOA	Other:		-	(Check only o		6 POther (S	nacifu)	ho-
<b>-</b> 8	fte.	Certification;	1. ■ Natural 5 Pending (Month, Day Year) Ir 2 Accident investigation	Time of njury	28c			28	Bd. Describe h			Journal	nospice
To the Hospitel or Attending	within 24 hours after death.  To the Funeral Director: A completely filled in by the fu		4 Homicide determined 28e. Place of Injury - At home, far building, etc. (Specify)						Bf. Location (S City or Tow	m, State	)		
the Hos	the Fun	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and manner stated.	, death o	stigation, in	my opin	ion, death	place, ar occurred	nd due to the d d at the time, d	ause(s) late and	and manner I place, and d	as state ue to th	ed. e cause(s)
T.	with To con	2	29b. Signature and title of certifier		29c. L	icense n	854		2	29d. Dai	te signed (Mo	nth, Da	v, Year)
(	E		30. Name and address of person who completed cause of death (Item 23a) (	Туре, Рг	rint)	) [	Rc.1	1: m	21-	2	71	フハ	2
: vê.	Stat Registra	-	31. Date filed (Month Day Year) DEC 1 0 2004  2. Registrar's Signature	1	lon v		1	P-111		(0	,	<u></u>	

		•	1 - For State of Maryland / Department Ce	artment of Health and M rtificate of Death	lental Hygie	Z 11 11 11 11 11 11 11 11 11 11 11 11 11
	Physici	an	1. Decedent's Name (First, Middle, Last)			Day Year S.Z. A.M.
	/Medic Examin		LEON F. BOSTON  4a. Facility Name (If not institution, give street and number)  ANNE ARUNDEL MEDICAL CENTER	4b. City, Town, or Location of Death ANNAPOLIS	NOVEMBER	4c. County of Death ANNE ARUNDEL
	Funeral Director		5. Social Security Number  6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 1 M 2 F 9 1 Yrs.  1 M 2 F	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 3-27-193	
	Maryland I-f show	tor	10a. State 10b. County 10c. City, Town or Lo			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	uth with the Ma 23a or 28a-fi ust be notified	ai Director	10e. Street and Number 1145 MADISON ST. APT A3	10f. Zip Code 21403		Citizen of What Country? USA
336	urs after death with the Maryla al', or ttems 23a or 28a-f shov Evaniever must be notiffed at	by Funerai	1 Never Married 2 Married 1 TY Yes 2 No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1☐ Yes 2∏ No Specify:	ecify Yes or No- Rican, etc.)	14. Race · American Indian, Black, White, etc. Specify: BLACK
21215-0036	within 72 ho nne. then "natur the lical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) -12-  College (1-4or 5+) -12-  CO	dent's Usual Occupation kind of work done during most of worki DO NOT use retired) OK	ing	. Kind of Business/Industry  EAFOOD RESTAURANT
Mary{and 2	e d a b	To Be Co	17. Father's Name (First, Middle, Last) LEON BOSTON		A STRICKN	•
Mary	s 1 and 2 should f Health and Mer itam 27 is marke othar traumatic			ng Address <i>(Street and Number or Rura</i> APT 2 ELROB CT. ANNAPOLI	al Route Number, Ci	
3altimore,	0 0		20a. Method of Disposition  1 \( \overline{\Delta}\) Burial 2 \( \subseteq\) Cremation 3 \( \subseteq\) Removal from State CROWNSVIL.	osition (Name of matory or other place) LE VETERANS 12-1-	2004 CRO	. Location - City or Town, State WNSVILLE, MARYLAND
Balt	permit. Pag Department Important: I any injury o		l	2. Name and Address of Facility WM 3		
小人心	Physician /Medical Examiner prujelitansit	Examiner	23a. Part 1. Enter the insease, or con plications that caused the death. Do not enter shock, or heart hiture. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	er the mode of dying, such as cardiac o	or respiratory arrest,	Approximate Interval Between Onset and Death
P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medical		⊒Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
	w requires that been signed I should be det	Completed by P	Part 11. Other significant conditions contributing to death but not resulting in the under the conditions contributing to death but not resulting in the under the conditions contributing to death but not resulting in the under the conditions contributing to death but not resulting in the under the conditions contributing to death but not resulting in the under the conditions contributing to death but not resulting in the under the conditions contributing to death but not resulting in the under the conditions contributing to death but not resulting in the under the conditions contributing to death but not resulting in the under the conditions contributing to death but not resulting in the under the conditions contributing to death but not resulting in the under the conditions contributing to death but not resulting in the under the conditions contributing to death but not resulting in the under the conditions contributing to death but not resulting in the under the conditions contributing to death but not resulting to death but not	ndertying cause given in Part I.	23e. Did tobacc	2 No 3 Probably 4 Unknown  24b. Were autopsy findings available
al Re	i <b>clan</b> : The lav certificate has rector, page 2			3 1,30	autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
Division of Vital Records,	ding Physician: n. After this certifica funeral director,	lon: To Be	25. Was case referred to medical examiner?  1			6 ☐Other (Specify)
Divisio	al or Attandi after death. I Diractor: A d in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str		28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edicai	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurre	ed at the time, date a	and place, and due to the cause(s)
	To To COM	W	29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type	29c. License number	3 (1	Date signed (Month, Day, Year)
	5		ERROL-A-Phillipmo A	002 Meduel P	Kuy, D	10+16 (M. en
	Sta Registr		DEC 1 0 2004 32. Registrar's Signature	Spach		

			For State Registrar	State of Maryl	and / Depa	artment of H	ealth and M Death		200	4 (	3909	L
			1. Decedent's Name (First, Middle, Last)					2. Date of Death		.,	3. Time of D	Death
	Physici /Medio		Arnetta Ri	ussell :	Beverly	7		$f{12}^{Month}$	Day 7	Year 04	8:10	ΑM
	Examir		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, or	Location of Death		4c. County	of Death		
				Home)			sco Par		AACO			
1	Funeral Director		5. Social Security Number 6. Sex 1 1	M 2X F 92	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) 2-1-1	(ear)	Coun	lace (State or i	
			Usual Residence of Decedent	52				<u> </u>	913	wasn	ingto	n, Do
	how		10a. State 10b. County	10c	. City, Town or Lo	cation	-			1/	0d. Inside City	Limits
	e Ma	Director	Md. AACO		Pataps	co Park					1 XYes 2	2 □ No
	or 28	Dire	10e. Street and Number			10f. Zip Code		100	g. Citizen of W	/hat Coun	try?	
	ath w		315 Key Ave.			21225			USA			
36	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-1 show is Modical Exartirat he notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒️Widowed 4 □ Divorced	<ol> <li>Was Decedent Ever in Armed Forces?</li> <li>1 ☐ Yes 2 X No If Yes, Give Year or Dates:</li> </ol>	'	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2☐ No	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		$^{\circ}$ - America k, White, $^{\circ}$ $^{\circ}$ Bla	etc.	
ò	2 hou atura	ted	15. Decedent's Educi	ation	16a. Deced	dent's Usual Occupa	ation	16	Sb. Kind of Bu			
215	d within 72 ho giene. ir than "natui the Modicol	Completed	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	(Give	kind of work done d DO NOT use retired,	luring most of worki )	ing			,	
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Maryland 21215-0036			19a. Informant's Name/Relationship (Type	· ·		ng Address (Street a						_ 1
	1 and 2 Health tem 27		Arnette C. Bate		b. Place of Dispo	7 Belle	Grove		imore			5
nor			1 X Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	IIIOVAI IIOIII State		sition (Name of natory or other place	I			,		
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licenses  Lloyd W. Este	•	arbutus E	Mem.Pk Name and Addres Step Br 300 Euts	· ; 12 s of Facility others ]	14-04 An Fu <u>n</u> eral	Ser,I	s,Md P.A.		
			23a. Part1. Enter the disease, or complic	ations that caused the d	death Do not ent	300 Eut	aw Place	e, Baltir	nore, N	Id.	21217 Approximate	
	D		shock, or heart failure. List only one	cause on each ine.	4			rospiratory arrest	.,		Interval Betwe Onset and De	en eath
	Physician /Medical		disease or condition resulting in death)		ncceou	tic co	100				1 mo	<u>S_</u>
ı	Examiner			Due to (or as a con	sequence ot);							
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	be executed sician and burial-transit	Examiner	Cause, Enter Underlying Cause (Disease or injury that initiated events  c.									
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8760,	cate be ex physician the buria	dlcal	d.									
9	ing pl	Med	IF FEMALE:						I			
.O. Box	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date Mon	of deliver th [	Ty Day Yea	ar
σ,		by P	Part II. Other significant conditions conti	ibuting to death but not	resulting in the ur	nderlying cause give	n in Part I.	23e. Did tobac	cco use contri	bute to the	e cause of dea	ith?
rd	w requires been sign should be							1 🗀 Yes	2 X No :	3 🗌 Proba	ibly 4 □Unk	known
Records,	> 9 0	ompleted						24a. Was an	24b. W	ere autop	sy findings ava	ailable
Ä	0 5 0	mo						autopsy performer	d? de	eath?	ipletion of caus	se of
Vital	sician: Th certificate irector, pag	Be C	25. Was case referred to medical examiner?				26. Place of Death		110		90,10	
of V	di is	2	1 ☐ Yes 2 No		2 ☐ ER/Outpatien	t 3 DOA Othe	r. 4 🗆 Nursing Hor	ne Residenc	e 6 🗀 Othe	r (Specify)	)	
חַ		on:	27. Manner of Death  **Description**  Description**  27. Manner of Death   28a. Date of Injury (Month, Day Year	28b. Time of Injury	28c. Injury Work	at 2	28d. Describe how	injury occurre	d			
sio	Attending r death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be				es 2□No					
Division	al or Attend s after death Il Director: /	Certification:	4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	At home, farm, stre ecify)	eet, factory, office	2	28f. Location (Stree City or Town, S	et and Numbe State)	r or Rural	Route Number	ζ,
	o the Hospital or Attan within 24 hours after deat to the Funeral Director: completely filled in by the	edical (	29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examine	cian: To the best of my er: On the basis of exam and manner stated.	knowledge, death nination and/or inv	occurred at the time restigation, in my op	e, date and place, a inion, death occurre	and due to the caused at the time, date	e(s) and man and place, ar	ner as sta nd due to t	ited. the cause(s)	
)	To the within 2. To the complet	W	29b. Signature and tale of certifier	AA.	3	29c. License	number 3	29d.	Date signed	(Month, D	9 700	150
9	41		30. Name and address of person who com	1) 000	10.	Print)	00	2121=1		• • • • • • • • • • • • • • • • • • • •	1) 000	-
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011	MI 47 D 4/0	204	DEC 1 0 2004	Elmerra	A.	1						

			1 - For State Regist	trar		State of	Marylan	d / Depa		t of H	ealth a		lental Hy		200	l,	39095
	Physici			nt's Name <i>(Fir.</i> dra Lea									2. Date of De Month DEC •		ay Y	ear 1	3. Time of Death 9:29 P M
	/Medid Examir					e street and num	ber)		4b. City,	Town, or	Location of	of Death	DIC.		c. County of		1 3.23
						dical Ce			1	apol.					Anne A		
	Funeral			ecurity Numbe 36–086.		Gex 1□M 2□F	Age (In yrs.	last birthday) Yrs.	If Under Months		If Under Hours	Min.	8. Date of Bir (Month, Da				place (State or Foreign htry)
	Director			idence of Dece		X	65						IUI.Y 3,	19.	39	Pe	nnsylvania
	rylanc how		10a. State		. County			y, Town or Lo								1	0d. Inside City Limits
	Se-f s	cto	MD		ne Aru	uaeī	Crov	vnsvil									1 ☐ Yes No
	with the	Dire		and Number Simms ]	Landin	r Road			10f. Zip	Code 2103:	2				itizen of Wha	at Cour	ıtry?
	ns 23	eral	11. Marital		Lanain	12. Was Deced	lent Ever in U.	.S. 13.	_1,			gin? (Spe	ecify Yes or No		USA 14. Race -	Americ	can Indian.
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Items 23a or 28e-f show any njury or other treumatic event, the Medical Examinar must be notified at ODEs.	by Funeral Director	1 🗆 Ne	ver Married		Armed Ford  1  Yes 2  If Yes, Give Year or Dat	∑XNo		lf Yes, spe≀ 1 □ Yes		n, Mexican Specify:	i, Puerto	ecify Yes or No Rican, etc.)		Black, Specify:		
21215-0036	2 hour			15. I	Decedent's E	ducation		16a. Dece	dent's Usua	al Occupa	ation			16b. I	Kind of Busir		
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Ž	should nd Me mark matic	၉		nant's Name/F		Type, Print)		19b. Mailir	na Address	(Street a			I Route Numb	ar. Citv	or Town. Sta	ita. Zin	(Code)
	nd 2 salth ar 27 is riteu			_		nusband							, Crown	-			
ore,	ss 1 a of Hea Item		20a. Metho	od of Disposition	on		20b. P	lace of Dispo	sition (Nar	ne of ther place	e)		ate		ocation - Cit		
Ĕ	Page ment ent: If ury o			urial 2 Cre onation 5 🗆		]Removal from Si fy)	tate				- 1	12/1	3/2004	El	kridje	, M	D
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P.O. B	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	by Physician/Med	in the	past 12 mont ∕es 2.ΣNo Jnknown			th 2∏Feta ntattimerofd vn		Ectopic pr Other (sp						Month		Day Year
ري ح	s that med to e deta	y Pi	Part II. Oth	er significant	conditions	contributing to dea	th but not res	ulting in the u	nderlying c	ause give	n in Part I.		23e. Did t	obacco	use contribu	te to th	ne cause of death?
ğ	w require been sig should b	ted t	144	perten	SION	Hype	rigia	toma	2 Pe	riph	cref		1 🗆	Yes 2	3E	] Prob	ably 4 □Unknown
ecc	has be ge 2 sh	Completed	/ /	CULAR	_				,				24a. Was	psy	prior	r to con	psy findings available inpletion of cause of
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ion	inding ath. ir: Afte	atio	1 Kana 2 ☐ Ac	_	☐ Pending investigatio		, Day Fear)	Injury	М		:7 fes 2 □ 1	No					
Division of Vital Records,	l or Attenor after death Director: I in by the	Certification:	3 □ Su 4 □ Ho	uicide 6 [ omicide	Could not be determined	286. Place C	of Injury - At ho g, etc. (Specif	ome, farm, str	eet, factory	, office		2	28f. Location ( City or To	Street a wn, Stat	nd Number o e)	r Aurai	l Route Number,
	To the Hospital or Attending Physiclen: The I within 24 hours after death.  To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	edical C	29a. Certifi (Checione)	ier 1 🔀	Certifying PI Medical Exa	nysician: To the b miner: On the bas and manne	sis of examina	wledge, death tion and/or in	n occurred vestigation	at the tim in my op	e, date and inion, deat	d place, a	and due to the ad at the time,	cause(s date an	) and manne d place, and	or as sta	ated. the cause(s)
	To the within To the comp	Me	29b. Signa	ture and title o	of certifier	4.5				License		7		29d. Da	ite signed (//	fonth, L	Day, Year)
	^		• (	YH	uen	14)				1)31	99-	<i>t</i>	70 199	12	19/0	24	
/	(M) -		30. Name a	and address o	f person who	completed cause	of death (Item	23a) (Type,	Print)	56	mo	1	1.6.	1	115	7 1	IUN I
Į.	Sta	te	31. Date fil	lod (Month, Da	D13001	0 200 P. Re	gis ir s Signa	ture	MA	No 1	ico,	/T/V/	VAPOLIS	+-	10 .	41	101
	Registr	18				2001	The state of the s	20	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 4.20PM heresa 2004 netnik Hmelice Dec /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hartore Reake If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1□ M 200 F Yrs. 218-MARYLAND Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatih and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23s or 28a-1 show any injury or other traumatic event, I'm Medical Examinat must be notified at 1 Yes 2 540 Director eci 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1904 Completed by Funeral ontra 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Memaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be KOZIK nm ပ Maryann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rd. 13541 TaylorStown 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City r Town, State 1

Burial 2 □ Cremation 3 □ Removal from State \*4 Donation 5 Dother (Specify) Gardensof Faith Cem. 12-10-04 21. Signature of Funeral Service Lice 4 ee 22. Name and Address of Facility BALTIMORE, MD 21234. 18th EVANS FUNERAL CHOPEL 8800 HARFORD RD 23a. Part . Enter the disease, in shock, or heart failure. Lift hat caused the detth. Do not enter the mode of dying, such as cardiac or respiratory arrest, and line. Approximate Interval Between Onset and Death Immediate Cau : (Final disease or condition resulting in death) **Physician** LUNG CANCER 17 MONTHS /Medical Due to (or as a consequence of): Examiner VER 3 MONTHS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has I funeral director, page 2 s 2 No 1 Tyes 2 0No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: Certification: To 1 ☐ Yes 2 🛣 No 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 No investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🕱 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D31856 Kokhazmo

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrar's Signature

DEC 1 0 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

602 S. ATWOOD RO # 106 BEL AIR MD 21014

			1 - For State Registrar	State of Maryland	-	artmen			and M	-	iene	0 L <sub>4</sub>	39097
			1. Decedent's Name (First, Middle, Last)							2. Date of Deat Month	h Day	Year	3. Time of Death
	Physici /Medio		SOANNE CLAR	K						Decimber		2004	3.15 A, M
	Examir		4a. Facility Name (If not institution, give	street and number)				Location o	f Death		4c. Cour	nty of Death	
			5117 GRUTON RO	nd		and the same of	Him				N	a	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. Ia		If Under Months	1 Year Days	If Under :	24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)	9. Birthi	place (State or Foreign ntry)
	Director		Usual Residence of Decedent	22	Yrs.					may 19	1950	r	1.0
	and		10a. State 10b. County	10c. City	, Town or Lo	cation							10d. Inside City Limits
	Mary 1 she	ō	MD N/c	B	Himo	-08							Yes 2□No
	28e	rec	10e. Street and Number		7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	10f. Zip	Code			1	0g. Citizen o	of What Cou	ntry?
	3e or	ቯ	5117 GREATEN R	no el		21	206				4.5		•
	ms 2	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S	3. 13. 1				gin? (Spe	ecify Yes or No- Rican, etc.)	14. R	ace - Ameri	
ß	r Ite		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No		_			, Puerto	Rican, etc.)	В	lack, White,	etc.
Ö	enrs a	by	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2	Z No	Specify:			Spec		CIC
2-0036	72 hours after death with the Maryland naturel', or Hems 23e or 28e-1 show disal Exantiner must be notified at	Completed	15. Decedent's Edu (Specify only highest grade	cation completed)	16a. Deced	dent's Usua	l Occupa	tion	of worki	na	16b. Kind of	Business/In	dustry
21	within ene.	nple	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of wor DO NOT us	4					,	
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yla	should be filed within of Mental Hygiene. markad other than imatic event, Ira Ma	ဥ	Charles PENC	in						1 Jac			
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	ss 1 and 2 of Health I itam 27 I		7.1.10.70.0	ic Sens	211		ton	Re	-	BALTIN			
Baltimore,			20a. Method of Disposition  1 ☑Burial 2 ☐ Cremation 3 ☐ R	emoval from State	ace of Dispo metery, cren	natory or of	her place				-	n - City or To	
Ē	permit. Page Department of Important: If any injury or ance.		' 4 □ Donation 5 □ Other (Specify)	KING	, Mere	mil	PARI	C 11.	2/11/	84	BAI	mong	MD
alt	permit. Pa Departmen Important: any injury once.		21. Signature of Funeral Service License	90	22	. Name and	d Addres	s of Facility	y 2	5 HS FC	nerm	Hui	ne
ш_	20599	(0 /	Theticia)	Bods		1129	N.			51 B		ne n	10 7/2/3
	Pnysician /Medical Examiner	her	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, Larry leading to minediate	Du No (or as a consequ	ence of):	nodf	Cre	J Sp	dr	me_	·		Approximate Interval Between Onset and Death
68760,	ficate be executed physician and s the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	ence of):								
P.O. Box (	law requires that the death certifical as been signed by the attending phy 2 should be detached for use as th	Physician/Med	1F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⑫ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3□	Ectopic pre Other (spe						Date of delive Month	ery Day Year
	w requires that the de been signed by the a should be detached		Part II. Other significant conditions cor	stributing to death but not resurved Seizuses	Iting in the ur	nderlying ca	iuse give	n in Part I.				ntribute to th	he cause of death? pably 4 Unknown
l Records,	The ate has page	Completed by	Malnubrition	() Carben	ia					24a. Was ar autops perform 1 Yes 2	ر الم	prior to co death?	psy findings available mpletion of cause of 2 No
Division of Vital	Physician: r this certific ral director,	Be (	25. Was case referred to medical examiner?						of Death	(Check only one	9)		
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n n	ng P fter t inera	ü	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28	3c. Injury Work	at ?	2	28d. Describe ho	w injury occ	urred	
Sio	endi eath. or: A	catl	2 Accident investigation			М	1 🗆 Y	es 2□N	10				
Ë	or Attending after death. Director: After in by the fune	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify,	ne, farm, str	et, factory,	office		2	28f. Location (Str City or Town		nber or Rura	ul Route Number,
Ω	rel C			J.,									
	To the Hospitel within 24 hours and to the Funerel completely filled	edical	29a. Certifier 1 Vertifying Physical (Check only one) 2 Medical Examination	sician: To the best of my know ner: On the basis of examinati and manner stated.	vledge, death on and/or inv	occurred a restigation,	it the time in my op	e, date and inion, deat	i place, a h occurre	and due to the ca ed at the time, da	use(s) and r te and place	manner as si e, and due to	tated. the cause(s)
	ithin ;	Med	29b. Signature and title of certifier	and mariner stated.		29c.	License	number		29	d. Date sinn	ned (Month,	Day, Year)
	F F F 8			20019			DI	753	37		-	-9-0	* * *
1	W		30. Name and address of person who compared to the second of the second	mpleted cause of death (Item	23a) (Type, W . MD	Print)	Loy.	f Av	1	Balto	21:	217	
	Sta	ate	31. Date filed (Month, Day, Year)	32. egistrar's Signati	ıre .	2			,				
	Registi		DEC 1 0 200	4 Stew 1	X AS	3462							

			For State Registrar	State of Marylan	-	artment of H			iene	39098
	Physici	an	1. Decedent's Name (First, Middle, Last)		Carrob	ro h		2. Date of Death	r <sup>Day</sup> , 2004	3. Time of Death 20:30 M
	/Medic	al	Estanislac  4a. Facility Name (If not institution, give str		Cayab		Location of Death	Decembe	4c. County of Death	<u> </u>
	Examin	lei	Southern Maryla			•	linton		Prince Geo	
	Funeral Director		5. Social Security Number  579=50-9816  Usual Residence of Decedent	7. Age (In yrs. 79	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 7,1	Year) 9. Birth Cou	place (State or Foreign intry) Llipines
	yland now		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	e Marian	ctor	Maryland Charles		Waldo	rf				1 ☐ Yes 2 🛣 No
	123a or 28 ust be no	ral Dire	10e. Street and Number 721 Berrington Drive	9		10f. Zip Code 20602		10	U.S.A.	ntry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 ⊕Yes 2 □ No 1f ¥es, Give 19 Year or Dates: 1056	50-	Was Decedent of H f Yes, specify Cuba I ☐ Yes 2 ☑ No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: Fil	etc.
2-0	72 hou nature	eted	15. Decedent's Educa (Specify only highest grade		16a. Deced	lent's Usual Occup	ation during most of work	ina	16b. Kind of Business/Ir	
12	within ane. Ihan "	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	oo NOT use retired Sar Tende:	1)		Hospitality	7
d 2	Hygie Other I	Be Co	17. Father's Name (First, Middle, Last)		1	ar rende.	18. Mother's Nam			4
/lan	Mental Mental arked	To B	Unknown				Unkn	own		
Baltimore, Maryland 21215-0036	and 2 sho balth and n 27 Is m er trauma		19a. Informant's Name/Relationship (Type Richard Cayabyab						City or Town, State, Zij	
more	Pages 1 and of He out of He out of He ry or other		20a. Method of Disposition  1 X Burial 2 ☐ Cremation 3 ☐ Rei  4 ☐ Donation 5 ☐ Other (Specify)			sition (Name of natory or other place Veterans		10,	oc. Location - City or T Che1tenham	
Balti	permit. Departm Importal any inju		21. Signature of Funeral Price Lensee		22	. Name and Addres	ss of Facility Lee	Funera1	Home, Inc.	
Н	- 1		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one	ations that caused the deat						Approximate Interval Between
E	Pnysician		Immediate Cause (Final disease or condition	Sensis						Onset and Death
R	/Medical Examiner		resulting in death)	Due to (or as a conseq						
	- 700	Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq						
	scuted ind transit	Examiner	cause. Enter Underlying Cause (Disease of Injury that initiated events resulting in death) Last							
8760,	cate be executed physician and the burial-transit	ical Ex	resulting in death) Last	Due to (or as a conseq	uence of):					
687	tificate ig phy as the	ledic	0.							
.O. Box 6	Attanding Physician: The law requires that the death certificate be executed r death.  r death.  actor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	b. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of degree of the second points of t	Ideath 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
Δ.	quires that en signed br	by	Part II. Other significant conditions control	+ ( .1	ulting in the ur	nderlying cause give	en in Part I.		acco use contribute to t s 2 □ No 3 □ Prot	**
l Records,	The law reate has bee	Completed	Chronic renal in	ufficiency				24a. Was an autopsy perform	prior to co death?	opsy findings available impletion of cause of
Viital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	spital:		Othe	ar.	Check only one		
ō	Phys or this oral dir	): To	1 ☐ Yes ②★No  27. Manner of Death	28a. Date of Injury	ER/Outpatien 28b. Time of	28c. Injun	4 □ Nursing Ho	me 5 🗌 Resider 28d. Describe how	nce 6 Other (Specif w injury occurred	(y)
ion	ath. ath. rr: Afte	atlor	2 Accident 5 Pending investigation	(Month, Day Year)	Injury	Work	<br Yes 2 □ No			
Division of	al or Atte s after de il Diracto id in by th	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stre y)	eet, factory, office		28f. Location (Str. City or Town,	eet and Number or Rura State)	al Route Number,
	To the Hospital or Attending Physician: The lawithin 24 hours after death. To the Funeral Diractor: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier (Check only one) 2 Medical Examine	cian: To the best of my known: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the time restigation, in my of	ne, date and place, pinion, death occurr	and due to the car ed at the time, da	use(s) and manner as s te and place, and due to	tated. o the cause(s)
	Tot Totl	M	29b. Signature and title of certifier	Dumais r	ID	29c. License	3813	29	d. Date signed (Month,	Day, Year)
i	541		30. Name and address of person who com	pleted cause of death (Item	1 23a) (Type, I		Road	Clint	on, MD	
	Sta		31. Date filed (Month, Day, Year) DEC 1 0 20	32. Registrar's Signa	E.	1	and .			
	<sup>⊭</sup> Registr –-	ar	DEC 1 0 20	04 Denew	100	span	es .			

			FOR	partment of Health and M <i>ertificate of Death</i>	lental Hygiene	4 39099
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physicia		SISTER MARLENE CUNNINGHAM			Year 004 10;15 A <sup>M</sup>
	/Medic Examin		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of	
	_Admin	٠.	MARIAS HEALTH CENTER	BALTIMORE		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd		8. Date of Birth	Birthplace (State or Foreign Country)
	Director		213-30-0858 1 M 2 X FX 71 Yrs	Wichins Days Flours Will.	(Month, Day, Year) 1/25/1933	MARYLAND
	pu &	}	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or	1 ocation		10d. Inside City Limits
	sho	ò		BURNIE		1 ☐ Yes A∑XNo
	the M	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of W	hat Country?
	with a or		335 MARGATE DRIVE	21060	U.S.A	
	leath	era				- American Indian,
Maryland 21215-0036	d within 72 hours after death with the Maryland Jiene. r than "natural", or Items 23s or 28s-f show the Medical Evair for must be netified at	by Funeral	Armed Forces?  1 ⚠ Never Married 2 Married  3 Widowed 4 Divorced  Armed Forces?  1 ↑ Yes, X\(\tilde{\tilde	<ol> <li>Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto</li> <li>Yes 2 XXio Specify:</li> </ol>		, White, etc. WHITE
Ö	2 ho	Completed	15. Decedent's Education 16a. De	cedent's Usual Occupation	16b. Kind of Bus	iness/Industry
215	within 72 ene. than "nai	ple	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	e. DO NOT use retired)	ng	
7	filed wil Hygiene ther tha	Con		DUCATOR	RELIGIO	US EDUCATION
pu	be filed ntal Hygid ad other event, I	Be	17. Father's Name (First, Middle, Last)		(First, Middle, Maiden Sumame	)
ya	should be and Mental s markad o	၉	PETER JOSEPH CUNNINGHAM	BARBAR		
Jar			, , , , ,	ailing Address (Street and Number or Rura		
	1 and 2 Health tam 27 I			S. PARKWAY, D200, sposition (Name of		008 Dity or Town, State
Baltimore,			1XXBurial 2 Cremation 3 Removal from State SISTER	rematory or other place)		•
Ë	t. Pa rtmer rtant rjury		'4 □Donation 5 □Other (Specify) the NAM	UR CEMETERY 12/ 22. Name and Address of Facility FI		T CITY, MD
Bal	permit. Page Department of Important: If any njury or once.		21. Signar sed Funeral Service Lorr KELLE GREGORY FINE ##101148	426 CRAIN HIGHWAY		•
						Approximate
	=		shock or heart failure. List only one cause on each line.	D 4		Interval Between Onset and Death
	Pnysician /Medical		Immediate Quise (Final disease or condition resulting in death)  a. Due to (or its a consequence of):	Januire .		2 weeks
н	Examiner		Full -Stave V	enal Films		Austric
	. 8 5	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	man juliane	. 1	1 444
11	e be executed rsician and e burial-transit	Examin	that initiated events	Glomemloner	histo 3	1 izear
0,	cate be executed obysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):	V		V V
8760,	cate be physici the bu	dical	d			
9		Med	IF FEMALE:			Ť
Вох	The law requires that the death certific tte has been signed by the attending p oate 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3 □Ectopic pregnancy	23d. Date Mon	of delivery th Day Year
0.	the a	/sic	1 Yes 20 No 4 Pregnant at time of death 9 Unknown	5 Other (specify)		,
<u>d</u> .	that the de sed by the a detached f		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacco use contri	bute to the cause of death?
Hecords,	signe d be	d by		,g g	1 ☐ Yes 2 X No	3 ☐ Probably 4 ☐ Unknown
Ö	w requir been si should	etec				ere autopsy findings available
e	has has	Completed			autopsy pr	ior to completion of cause of eath?
a			Of Was ages retayed to modical	00 Bl / B		☐Yes 2☐No
Vital		o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 N ER/Outpa	Other	n <i>(Check only one)</i> me 5 ☐ Residence 6 ☐ Othe	Manateaith
o		H- 1	27. Manner of Death 28a. Date of Injury 28b. Tim	e of 28c. Injury at	28d. Describe how injury occurre	1.036
on	nding I th. : After s funer	tlor	1 Natural 5 ☐ Pending (Month, Day Year) Inju	ry Work? M 1 ☐ Yes 2 ☐ No		
Division	or Attending after death. Director: After In by the fune	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm	street, factory, office	28f. Location (Street and Numbe City or Town, State)	r or Rural Route Number,
Ö	s afte	Certification:	4 Homicide building, etc. (Specify)		City of Town, State)	
	To the Hospital or Atte within 24 hours after de To the Funeral Direct completely filled in by II	edical	29a. Certifier (Check only (Check only 2 Medical Examiner: On the basis of examination and/or	eath occurred at the time, date and place, r investigation, in my opinion, death occurr	and due to the cause(s) and man ed at the time, date and place, a	ner as stated. nd due to the cause(s)
	o the o the omple	Med	one) and manner stated.  29b. Signature and title of pertitier	29c. License number		(Month, Day, Year)
	8 <del>-</del> 1 € - H		· (Emi in)	N56623	12/0	6/2000
7			30, Name and address of berson who completed cause of death (Item 23a) (Ty	pe, Print)		-1
	10		Jin Gu, MD 7505 6	Oster Dr. #403	Towson 1	UD 21204
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature		,	
	Registi	rar	DECI 0 2004 Beneva 15	Spart 1		
-				1-1 010		

DHMH 17 Rev 1/2001

ORIGINAL

S		1 - State Registrar	nel .	C	ertificate (	of Deat	h		Reg. No.	. 0 0 %	3910
Physicia	in	1. Decedent's Name (First, Middle, La:  BEATRICE SC		MIDN				2. Date of De Month	Day	Yeer	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, give		NEI	4b. City, Tow	n, or Location	n of Death	Decemb		2004 ounty of Dea	10:26 p
LAGIIIII	G1	412 Laurel Avenue	in e		Laure						eorge's
uneral		5. Social Security Number 6. S	eres eres	In yrs. last birthda	(f) If Under 1 Y	ear If Unde	er 24 Hrs.	8. Date of Bir (Month, Da	th v. Year)	9. Bir	thplace (State or Forei
ctor		217-05-5092 1 Usual Residence of Decedent	□M 2½F 9	U Yrs.				May 13	, 191	4 Ma	ryland
ם		10a. State 10b. County		Oc. City, Town or	Location						10d. fnside City Limit
Table 1	ctor	MD Prince G	eorge's	Laurel							¥ØYes 2□N
70 80	Director	10e. Street and Number			10f. Zip Coo	de			10g. Citize	n of What Co	ountry?
The state of		412 Laurel Avenue	10 Was Bassier 5			707			U.S		
	Funeral	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2XXXIII	er in U.S. 13	. Was Decedent If Yes, specify (		ingin? (Spe an, Puerto I	city Yes or No Rican, etc.)	14	Black, Whit	erican Indian, le, etc.
2	ρ	3XXWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 <b>∑</b>	No Specif	y:		S	pecify:	White
	Completed	15. Decedent's Ec (Specify only highest gra	Jucation de completed)	16a. Dec	edent's Usual Oc	cupation	st of working	70		of Business	,
e Ma	du	Elementary/Secondary (0-12) Grade 12	College (1-4or 5+)	1	e kind of work do DO NOT use re eteria M			.9		Count	Y ool System
		17. Father's Name (First, Middle, Last)		car	occira i			(First, Middle,			OOI System
	To Be	Felix Foote					es Di				
traumatic	_	19a. Informant's Name/Relationship (7	Type, Print)	19b. Mai	ling Address (Str	eet and Num	ber or Rura	Route Numbe	er, City or T	own, State, 2	Zip Code)
other tra		Darlene Blaney /	daughter		Longfell			Hermos	a Bead	ch, CA	90254
	П	20a. Method of Disposition 1 □ Burial 2XX remation 3 □	Removal from State		ematory or other	piace)		ate		tion - City or	
		*4 ☐ Donation 5 ☐ Other (Specify	(v)	West Aru				9/2004		nton,	Maryland
once.		21. Signature of Funeral Service Licen		00160	22. Name and Ad Donalds 313 Tal	on Fun	eral	Home,	2.A.	arulan	d 20707
		23a. Part1. Enter the disease, or comp	plications that caused the							ar y raii	Approximate
an		shock, or heart failure. List only Immediate Cause (Final disease or condition		gkins Lyı	nphoma						Interval Between Onset and Death Years
al er		resulting in death)	Due to (or as a co		•						
	_	Sequentially list conditions,	b. Due to (or as a c.	needs on all							
	Examiner	Sequentially list conditions. Tary, leading to minimaliate cause. Enter Underlying Cause (Disease or injury		orresquer de ory.							
	20	that initiated events resulting in death) Last	c. Due to (or as a co	onsequence of):							
101-11011	ш	Todaking it: dodany zast								1	
	ā	issuing in south) East	d								
3	ā		. d								
	ā	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p	Fetal death 3	□Ectopic pr <b>eg</b> na				230	I. Date of deli	•
1	ā	IF FEMALE:		Fetal death 3	□Ectopic pregna□ Other (specify				230	I. Date of deli	ivery Day Year
	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3 e of death 5	Other (specify	)	1.	23e. Did to		Month	•
	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊠No 9 □ Unknown	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3 e of death 5	Other (specify	)	I.			Month contribute to	Day Year the cause of death?
	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊠No 9 □ Unknown	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3 e of death 5	Other (specify	)	I.	1 □ Y	obacco use	Month contribute to	Day Year the cause of death?
	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊠No 9 □ Unknown	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3 e of death 5	Other (specify	)	I	1 □ Y	obacco use	Month  contribute to  3 Pro  4b. Were au prior to death?	Day Year the cause of death?
	Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 Who 9  Unknown  Part II. Other significant conditions co	1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown  ontributing to death but n	Fetal death 3 e of death 5	☐ Other (specify	given in Part		1 □ Y	obacco use  yes 2 🖎 1	Month  contribute to  3 Pro  4b. Were au prior to death?	the cause of death?  obably 4 Unknow  topsy findings availab completion of cause of
	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part fl. Other significant conditions of the past 12 months?  25. Was case referred to medical examiner? 1 Yes 2 No	1 Live birth 2 C 4 Pregnant at tim 9 Unknown  ontributing to death but n	Fetal death 3 a e of death 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	Other (specify underlying cause	given in Part  26. Plac  Other: 4 \( \) N	e of Death ursing Hom	1 Yes  24a. Was autop perfor 1 Yes  (Check only one 5 X Yeside	an 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Month  contribute to 3 □ Pri  4b. Were au prior to c death? 1 □ Yes  Other (Special Contribution of the Co	the cause of death?  obably 4 □Unknow  topsy findings available  ompletion of cause of
	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	1 Live birth 2 Liv	☐ Fetal death 3 e of death 5  ot resulting in the  2 ☐ ER/Outpatie 28b. Time	Other (specify underlying cause and 3 DOA 28c. In	given in Part  26. Plac  Other: 4 \( \) N	e of Death ursing Hom 28	1 Yas autop perfor 1 Yes	an 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Month  contribute to 3 □ Pri  4b. Were au prior to c death? 1 □ Yes  Other (Special Contribution of the Co	the cause of death?  bably 4 □Unknow  topsy findings available  completion of cause of
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the tuneral director, page 2 should be detached for use as the but	Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part fl. Other significant conditions of examiner? 1  Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 9 Gould not be determined	1 Live birth 2 Liv	Fetal death 3 e of death 5  ot resulting in the  2 ER/Outpatie par) 28b. Time Injury  At home, farm, s  Specify)	Other (specify underlying cause  nt 3 DOA of 28c. Ir M 1 reet, factory, office	26. Place Other: 4 Nork? Yes 2 Ce	e of Death ursing Hom 28 3 No	24a. Was autop performed in Yes (Check only on e 5 (X Kesidad Describe has a City or Tow	ovbacco use  (es 2 1)  an  sy  sy  med?  an  ence 6 cow injury of  treet and N  n, State)	Month  contribute to  3	the cause of death?  obably 4 □Unknown  topsy findings available  completion of cause of  2 ☒️IXIo
the tuneral director, page 2 should be detached for use as the but	Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part fl. Other significant conditions of the past 12 months?  25. Was case referred to medical examiner? 1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide determined  29a. Certifier (Check only 2 Medical Exam	Hospital:  28a. Date of Injury (Month, Day Ye)  28e. Place of Injury building, etc. (5)  ysician: To the best of eximals.	□ Fetal death 3 se of death 5 steed death 5 steed death 5 steed of the second of the	ont 3 DOA of 28c. Ir M 1 reet, factory, offi	26. Plac Other: 4 Nork? Yes 2	e of Death ursing Home 20 3No	24a. Was autop perfolio 1 Yes (Check only or e 5 X Kesid ad. Describe h	an 22 No and a contract and No. State)	Month  contribute to  do 3   Production of the contribute to death?  1   Yes  Courred	the cause of death?  the cause of death?  bably 4 □Unknown  topsy findings available  completion of cause of  2 ☒ ☒ ☒ io  cify)  ral Route Number,
pletely filled in by the funeral director, page 2 should be detached for use as the bur	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	1 Live birth 2 Liv	□ Fetal death 3 se of death 5 steed death 5 steed death 5 steed of the second of the	ont 3 DOA of 28c. Ir M 1 reet, factory, officeth occurred at the	26. Plac Other: 4 Nork? Yes 2	e of Death ursing Home 20 3No	24a. Was autop performed to the control of the cont	an 22 No 22 No 22 No 22 No 24	Month  contribute to  do 3   Production of the contribute to death?  1   Yes  Courred	the cause of death?  the cause of death?  babably 4 □Unknown  topsy findings available  completion of cause of  2 ☑ ☑ ☑ ☑  crity)  ral Route Number,  stated.  to the cause(s)

State Registrar DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)
DEC 1 0 2004

32. Registrar's Signature

			For State Registrar	State of	Maryland / Do	epartment Certificate	of Health of Deal	n and Me	ntal Hy	gienez (	004	39	101
	Physici		1. Decedent's Name (First, Middle, I Frances Pauline						Month	Day	Year	3. Time o	М
	/Medio Examir		4a. Facility Name (If not institution, g		Der)	4b. City, T	own, or Location		ecemb	er 7,	2004 Inty of Deat	9:55	a
	LXaiiiii		4800 Yellowwood					imore		N/A			
Ī	Funeral Director		5. Social Security Number 6. 218-12-3442	Sex 7. 1 M 2 X F	Age (In yrs. last birth	Months	Year if Und Days Hour	's Min.	. Date of Bin (Month, Da	y, Year)	Co	nplace (State	or Foreign
			Usual Residence of Decedent					J	ul 14	, 1917	Mar	yland	
	inylan show	_	10a. State 10b. County		10c. City, Town	or Location						10d. Inside C	*
	Ba-f s	cto	MD N/A		Baltimo								2 🗌 No
	with th	Funeral Director	10e. Street and Number			10f. Zip (				10g. Citizen		,	
	leath	eral	4800 Yellowwood .	Avenue, A	-	2120		Origin? (Speci	fy Yes or No	United		ces ncan Indian.	
9	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show avant, the Medical Examinar must be notified at	Fun	1 Never Married 2 Married	Armed Forc	es?	13. Was Decede	,		can, etc.)		Black, White		
203	72 hours "natural",	d by	3 Widowed 4 Divorced	Year or Date	es:	1 🗆 Yes 2	No Spec	ту:			к <i>ify:</i> Вlac		
15-(	"nate	Completed	15. Decedent's (Specify only highest of	Education grade completed)	(4	ecedent's Usual Give kind of work fe. DO NOT use	done during m	nost of working		16b. Kind o		-	
12	withii iene. r than	omp	Elementary/Secondary (0-12)	College (1-4	lor 5+)	embler	761860)			FIECTI	OHICS		
Maryland 21215-0036	e filec al Hyg othe vant,	Bec	17. Father's Name (First, Middle, La	st)			18. Mc	other's Name (i	First, Middle,	Maiden Sun	nam <i>e)</i>		
<u>ylar</u>	should band Ments I marked	ToE	George Tittle				Ber	tha Ro	binso	n			
lar	2 sho and is mu		19a. Informant's Name/Relationship			Mailing Address (							
	1 and 1ealth Im 27 Ihar tu		Mr. Donald Colbe	rt/Husban		0 Yellov		venue,					)
Baltimore,	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natur any injury or other traumatic avent, the Madical Once.		1 ☐ Burial 2 🗷 Cremation 3		alo	isposition (Name crematory or oth		De	c 9	20c. Locatio			
ij	artme ortani injury		<ul> <li>4 ☐ Donation 5 ☐ Other (Spec</li> <li>21. Signature of Funeral Service Lice</li> </ul>		Chesap	eake Cre		2 0	-	Beltsv		MD	
Ba	permit. Departr Imports any inj		1 Sty	lill_	M00884	22. Name and Cremat 8717 G	ion and reen Pa			ernati Balt	ves imore	. MD	
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cau ly one cause on eac	used the death. De no	enter the mode	of dying, such	as cardiac or r				Approximat Interval Bet	e ween
	Physician		Immediate Cause (Final disease or condition	a (	g'astr	ic Ca	nané	ma				Onset and	n Thy
	/Medical Examiner		resulting in death)	Due to (or	as a consequence of)	:							
		ь	Sequentially list conditions, if any, leading to immediate	b	r as a consequence of)								
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Unidentified Cause (Disease or injury that initiated events										
ó	The law requires that the death certificate be executed tee has been signed by the attending physician and page 2 should be detached for use as the burial-transit		resulting in death) Last	Due to (or	as a consequence of)	:							
8760,	ate be hysici the bu	dical	•	d									
9	nding p	/Mec	IF FEMALE:	23c. If yes, outco	ome of pregnancy								
Вох	eath certifi attending I for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1☐Live birt	h 2 Fetal death	3 Ectopic preg					Date of delin Month		Year
P.O.	that the di ad by the detached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknow		5 <u>—</u> 6 ( 9 5 6 .							
	es that igned b	by P	Part II. Other significant conditions	contributing to dea	th but not resulting in the	ne underlying cau	ise given in Pa	rt I.	23e. Did to	obacco use c	ontribute to	the cause of c	leath?
Vital Records,	v require been sig should b	ted							1 🗆 \	res 2. DMo	3 □ Pro	bably 4 🗆	Jnknown
ecc	e law r has be je 2 sh	Completed							24a. Was autop	sv	b. Were aut	opsy findings ampletion of c	available ause of
<u>=</u>		Con							perfo	rmed? 21 No	death?	2□ No	
Vita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				ace of Death (0					
	Phys r this ral dii	. To	1 Yes 2 No	1 1 1 Inb			c. Injury at	Nursing Home		tence 6 🗆 0		ify)	
on	Attanding Physician: r death. sctor: After this certification the funeral director, I	atlor	1 atural 5 Pending 2 Accident Investigat	28a. Date of (Month,	Day Year) Inju		Work? 1 ☐ Yes 2						
Division of	Attandii er death. actor: A by the fu	Certification:	3 ☐ Suicide 6 ☐ C uld not termine	289. Place of	f Injury - At home, farm	, street, factory,	office	28f	Location (S	Street and Nu	m <i>ber</i> or Rur	al Route Num	ber,
Ö	ital or its after ral Dii	Cer	/		, oto. (oposity)				ony or row				
	To the Hospital or Attandir within 24 hours after death. To the Funeral Director: Al completely filled in by the fu	Medical	(Check only 2 Medical Ex	aminer; On the bas	est of my knowledge, of is of examination and/	leath occurred at or investigation, in	the time, date n my opinion, d	and place, and leath occurred	due to the dat the tale.	cause(s) and date and plac	manner as : e, and due t	stated. to the cause(s	)
	o tha ithin 2 o tha omple	Med	one)  29b. Signatur and title of certifier	and manne	r stated.	29c.	License numbe	ər		29d. Date sig	ned (Month,	Day, Year)	
	⊬ ≯ <u>∓</u> ⊻		redy 1.	Antis	Mis	, 7	777	645		12/9	8/04	1	
	$\cap$		30. Name and address of person wh	completed cause	of death (Item 23a) (Ty	rpe, Print)					7-1		
	\		FREDRICS. S	INKS 1	hiD. 750	5 OSL	ERDR	: SUITE	306	TOW SOA	1, MD	0515;	9
\	Sta Regist	-	31. Date filed (Month, Day, Year) DECT 0 20	04 32. Reg	gistrar's Signature	don	Ke				/		

			1 - For State Registrar		aryland / Dep		Health and I	Mental Hygid	ene 2004	39102
	Physici		Decedent's Name (First, Middle, La     Ralph		hapman			2. Date of Death Month Decembe	Dey Year	3. Time of Death 12:25 AM
1	/Medic Examir		4a. Fecility Name (If not institution, gi	re street and number)			or Location of Death		4c. County of Death	
Fs.			Collingswood Nurs  5. Social Security Number 6.			Rockvi		R Date of Righ	Montg	
	Funeral Director		094-16-4570  Usual Residence of Decedent	15⊈M 2□F	e (In yrs. last birthday, 87 Yrs.	Months Day		8. Date of Birth (Month, Day, ) June 19, 1	rear) S. Birth 1917 New	plece (Stete or Foreign htry) York
	Maryland I-f ehow	tor	10a. State 10b. County Maryland Montgom	ery	10c. City, Town or L Bethesda	ocation				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	or 28s	Sire	10e. Street and Number			10f. Zip Code		100	g. Citizen of What Cou	ntry?
	ath wi	rai	7704 Hemlock Stre			2081			nited State	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 ie marked other then "natural", or items 23e or 28e-f ehow other traumatic event, the Medical Examinational be notified at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☑ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 X Yes 2 If Yes, Give Year or Dates:	Ever in U.S. 13. No 1943 – 1972	Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ② No	Hispanic Origin? (S ban, Mexican, Puert o <i>Specity:</i>	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
21215-0036	thin 72 hou e. en "nature Modical E	Completed by	15. Decedent's E (Specify only highest g. Elementary/Secondary (0-12)		16a. Dece (Give life.		e during most of wor ed)	tking	6b. Kind of Business/In	dustry
21	ygien ygien her th	Con	-		5+ Gen	eral Sur	<u> </u>		Medicine	
Maryland	should be filed within and Mental Hygiene.  marked other then "umatic event, the Men	To Be	17. Father's Name (First, Middle, Las Mark Chapman				Nellie	wilson Cl	hapman	
Mar	12 sho h and 7 ie my traum		19a. Informant's Name/Relationship			-			City or Town, State, Zip	
	1 and Healt em 2		Ruby Louise Chap  20a. Method of Disposition	man/ wire	20b. Place of Dispo	sition (Name of		Date 20	Maryland 2 Dc. Location - City or To	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 it eny injury or other tra		1 ₺ Burial 2 □ Cremation 3 1	(y)	National	matory or other pi CON Cemeter Name and Add ethesda- Reth	y 20 Ro	ary 3, 05 A bert A. Po se, Inc., vland 208	rlington, Numphrey Fun 7557 Wisco 14-3501	/irginia neral Home/ onsin Avenu
) 	Physician /Medical Examiner		23a. Part 1. Enter the disease, or constock, for flear failure. List only Immediate Cause (Phadidisease or condition resulting in death)	a Cardio	the death. Do not enne.  Pulmonary a consequence of):	ter the mode of dy	ring, such as cardiac	or respiratory arres	t.	Approximate Interval Between Onset and Death
68760,	cate be executed oblysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to introduce cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С.	a consequence of):					
P.O. Box 6	The law requires that the death certificate ate has been signed by the attending phy page 2 should be detached for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnan Other (specify)	су		23d. Date of delive Month	ery Day Year
	signed b	y P	Part II. Other significant conditions	contributing to death b	ut not resulting in the u	nderlying cause g	iven in Part I.	23e. Did toba	cco use contribute to th	ne cause of death?
ords	w require been sig should b	ed t	Hypertension	Periphera	ıl Vascular	Disease	2	1 🗆 Yes	2 □ No 3 No Prob	abiy 4 []Unknown
Vital Records,	Physician: The law re this certificate has be ral director, page 2 sh	Complet	Diabetes Meli	itus				24a. Was an autopsy performe	prior to con death?	psy findings available mpletion of cause of
/ita	cian: ertific ector,	Be	25. Was case referred to medical examiner?	Haspitali				th (Check only one)		
<del>j</del> o	Physician: this certificant	2	1 ☐ Yes 2 X No 27. Manner of Death	Hospital: 1 Inpatie		IL 3LI DOM		ome 5 Residence 28d. Describe how	ce 6 Other (Specification)	y)
Division	To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	1 Natural 5 ☐ Pending 2 ☐ Accident investigate 3 ☐ Suicide 6 ☐ Could not	De Place of Ini	y Yeer) Injury	M 1[	]Yes 2□No		et and Number or Rura	I Route Number.
Di	pital or A burs after eral Direc		4 Homicide determined	building, et	c. (Specify)			City or Town,		
	the Hos in 24 ht the Fun	Medical	(Check only 2 Medical Exa	miner: On the basis o and manner st	f examination and/or in	vestigation, in my	opinion, death occu	rred at the time, date	e and place, and due to	the cause(s)
	viti con	2	29b. Signature and title of certifier	lu			0060036	290	December	Dey, Year) 6, 2004
1	641		30. Name and address of person who Mahmoud Doski, I			Print)		ng, Maryla		
	Sta		31. Date filed (Month, Day, Year)		ar's Signature	1000	Pot.			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

			1 - State Ragistrar		Cer	tificate of	Death	F	Reg. NG. UU	39103
	Physicia /Medic	al	Decedent's Name (First, Middle, Las Melvin Dubo	•				2. Date of Dea Novembe	er <sup>D</sup> 30, 200	3. Time of Death 11:00 Р м
	Examin		4a. Fecility Name (If not institution, give street and number) Laurel Regional Hospital			4b. City, Town, or Location of Death Laurel			4c. County of Death Prince George's	
	Funeral Director		5. Social Security Number 6. Social Security Number 1  Usual Residence of Decedent		e (In yrs. last birthday) 32 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day	y, Year)	Birthplace (State or Foreign
	/land		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	a-fst	ctor	MD Prince (	Georges		Lau	re1			1 TX Yes 2 □ No
	within 72 hours after death with the Maryland ene. then "natural", or itams 23a or 28a-1 show the Medical Examiner must be notified at	by Funeral Director	10e. Street and Number 8882 Cherry Lane			10f. Zip Code	20707		10g. Citizen of What USA	Country?
	r deat	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A Black, W	merican Indian, /hite, etc.
9036	ours afte rral', or it l'Exemin	d by Fi	Never Married 2 Married  3 Widowed 4 Divorced	1 ☐ Yes XX If Yes, Give Year or Dates:	No	XXYes 2□ No	Specify: Hand		Specify:	White
<u>7</u>	n 72 t "nati	lete	15. Decedent's Ed (Specify only highest gra	de completed)	(Give	ent's Usual Occup kind of work done o OO NOT use retired	during most of work	ing	16b. Kind of Busine	ss/Industry
212	d withi giene. r than	Completed	Elementary/Secondary (0-12)	College (1-4or :	5+)	Welder	,			Meta1
Maryland 21215-0036	ld be filed ental Hyg ked otha ic evant,	To Be C	17. Father's Name (First, Middle, Last) Victor Dubon					e (First, Middle, rida Rome)	Maiden Sumame)	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural; or itams 23a or 28a-1 show any injury or other traumatic event, the Medical Exercitor must be redified at once.	ř	19a. Informant's Name/Relationship (7 Victor Dubon	ype, Print)	19b. Mailin	g Address (Street a	and Number or Run	a <i>l Route Numbe</i> <b>3, MA</b> 12	r, City or Town, State	a, Zip Code)
Baltimore,	of Head of Head fitam rothe		20a. Method of Disposition	Damauel from Chata	20b. Place of Dispos	sition (Name of place)	:e)	Date	20c. Location - City	or Town, State
Ë.	Page ment tant: If		1 ☐ Burial 2 ☐ Cremation 3 🔀 4 ☐ Donation 5 ☐ Other (Specify	)	Woodlawn O		December 6	, 2004	Everett,	MA
Ball	permit Depart Import any in		21. Signature of Funeral Service Licen	see Victor	P. Doda 22 Ch	Name and Address arles L. Ol East	ss of Facility Stevens Fort Aver	Funeral nue, Bal	Home, In	C. 21230
Ü			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that cause one cause on each li	the death. Do not ente	r the mode of dyin	g, such as cardiac			Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. 00	nshet	Muss	51 po (	Les	100	Olisat and Death
	Examiner	iner			a consequence of):					
7	P #		Sequentially list conditions, b. Due to (or as a consequence of): cause. Enter Underlying							
A Ir	xecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):					
68760,	certificate be executed and ording physician and use as the burial-transit			d						
89 xc	ertifica ding ph	//Medical	IF FEMALE:	000 16						
Bo			in the past 12 months?	23c. If yes, outcome 1☐Live birth 4☐Pregnant at	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of o Month	delivery Day Year
Ö.	it the d by the tached	by Physicia	1	9□ Unknown						
s,	To tha Hospital or Attanding Physician: The law requires that the death within 24 hours after death.  To tha Funaral Diractor: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for a		Part II. Other significant conditions co	ontributing to death b	ut not resulting in the un	derlying cause give	en in Part I.		- 0	to the cause of death?
oro	requi	Completed						1 🗆 Y		Probably 4 Unknown
Rec	he law e has l	lduuc						24a. Was a autops	sy prior t med? death	autopsy findings available to completion of cause of ?
Division of Vital Records, P.	ian: T	To Be Co	25. Was case referred to medical				26. Place of Deatl	(Check only or		es 2 No
) ( <	hysic this ce al direc		INV 182 5 140	Hospital: 1 ☐ Inpatie			4   Nursing no	me 5 🗆 Reside	ence 6 Other (Sp	pecify)
uc	ding P	tlon:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Ite of Inju	ry Year) 28b. Time of Injury	28c. Injury Work		28d. Describe h	ow injury occurred	05/10
/isi	Attend r death ctor: by the	ficat	3 Suicide 6 Could not be	28e. Place of Inj	ury - At home, farm, stre			28f. Location (S	treet and Number or	Rural Route Number,
ρiς	s after s after al Dire	Certification;	4 Homicide determined	building, et		NE	5	City or Town	Dorra la	ane 20708
	To tha Hospital or within 24 hours afte To tha Funaral Dir completely filled in	Medical	29a. Certitier (Chock of the cause (s) and manner as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	o tha ithin 2 o tha omple	Med	29b. Signature and title of certifier	and manner sta	ated.	29c. License	number	2	29d. Date signed (Mo	inth, Day, Year)
)	- 5 <del>-</del> 0		Y glorfer	MI		0	.C.M.E.		December (	01, 2004
	1		30. Name and address of person who d	completed cause of d			t, Baltim	ore, Ma	ryland 212	201
	Sta		31. Date filed (Month, Day, Year) DEC 1 0 200		ar's Signature	4				
DH	Registr MH 17 Rev 1/2		DEC 1 0 200	4 Stens	ve g	Lords	/			
-11	17 NOV 1/20	501				,				

Dondalski STANley

			State of Manyland / Department of Health and Mantal Hydiana
		-	State of Maryland / Department of Health and Mental Hygiene  1- State Registrar  State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Reg. No. 2014 39104
			1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death
	Physici		STANLEY, R. PONDALSIKI, SR 12 7 2004 11:47 AM
	/Medic Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
	LXdiiiii		Lorien @ Riverside Belcamp Harford
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Oate of Birth Old On the Day Year Country Amounts Day Year (Month Day Year)
	Director		2(6 - 24 - 7 844 1 M 2 F / 4 Yrs. Months Bays 110013 MM 4 3, 1930 MS.  Usuat Residence of Decedent
	show		10a. State 10b. County • 10c. City, Town or Location 10d. Inside City Limits
	Many Firsh	to	MD BALTIMONE DUNDALK 1 TYPES 2 1/2 NO
	with the Marylar a or 28a-f show be rediffed at	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
	death with the Maryland ms 23s or 28s-f show rmust be rollined at	rai	7928 ST. CLARE LD. 21222 U.S.A.
		Funerai	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 2 No 5.
336	hours after tural', or ite al Examina	by F	3 Wildowed 4 Divorced Year or Dates: ACRFOCCE 1 Yes 2 No Specify: Specify: While
21215-0036	72 hours natural', ilical Exa	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working
21	within 72 ene. then "nai	mple	Figmentary/Secondary (0-12) Coltege (1-4or 5+)
12	be filed with tal Hygiene d other the event, Item	S	17. Father's Name (First, Middle, Last)
anc	o d ab	o Be	STANLEY DONDALSKI Josephine Symowski
Maryland	should be and Menta is marked sumatic ev	은	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	rt.		STANLEY-R. Dondalski, JR 7928 ST. CLARELD. BAHO. NO 21222.
ore,	Pages 1 a ment of Hea ent: if item jury or othe		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State
Ĕ	nit. Pag artment ortent: i injury o		"4 Donation 5 Dother (Specify) Criton brunt Holly Hills Cen. 110/64 13 A 170. MU
Baltimore,	Provident Medical Examiner		21. Siznatury & Funeral Service Licensee 22. Name and Address of Facility STELLA FUNELAL ITOPIC (ITT).  HORTIEN MILLER STELLA
			2 Part Enter the disease or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest.  Approximate
			25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death
			Immediate Cause (Final disease or condition resulting in death)  a.   Due to (or as a consequence of):
			Sequentially list conditions b.
	p =	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events cause.
	and and I-trans	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):
760,	aath certificate be executed attending physician and for use as the burial-transit	cai E	
687	ificate g phy: as the		u.
Вох	h cert endin	M/us	IF FEMALE:     23c. If yes, outcome of pregnancy     23d. Date of delivery       23b. Was decedent pregnant     1 □ Live birth     2 □ Fetal death     3 □ Ectopic pregnancy     Month     Day     Year
	e deat	sicis	in the past 12 months?  1
P.0	that the death cer ed by the attendir detached for use	by Physician/Med	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?
ds,	Se Go	d by	At al Shulletien / At al Mutter 100 3 Probably 4 Unknown
COL	w require been si should I	ete	his try of cardiae arest 24a. Was an autopsy findings available prior to completion of cause of
Vital Records,	sicien: The law certificate has b irector, page 2 s	Completed	autopsy performed? performed? death?    Ang Cane   Ang
ita	intifica	BeC	25. Was case referred to medical  26. Place of Death (Check only one)
	hysic his ce il direc	P	1 Yes 2 Sto Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)
o uc	ding Phys	ion:	27. Manner of Death  28a. Date of Injury (Month, Day Year)  28b. Time of Unitry 28c. Injury at Work?  New Year  New
Division of	ttendi death. ctor: A	icat	3 Suicide 6 Could not be 28e Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number,
Div	after after Dire	erti	4 Homicide determined determined building, etc. (Specify)
	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical Certification:	29a. Certifier  (Check only 2   Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only 2   Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	the Hi nin 24 the Fi	ledi	one) and manner stated.
	<b>5</b> ₩ <b>1</b> 000	2	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
	*		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  A Mun Milwe um 6/5 Mac Mind Ad Bel An Mn21014
		ate	31. Date filed (Month, Day, Year) (32. Registrar's Signatury apacks)
	Regist	rar	DEC 1 0 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygienes 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician HARVALIATA VINDARO DITTERBER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death Examiner 2951206EWDOOD HVS If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country). 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min 1□M 2/1 F Months Days Hours Arb-26 1906 Yrs. 20 Director 300F-10-116 Usual Residence of Decedent death with the Maryland 10c City Town or Location 10b. County 10d Inside City Limits 10a State 7 is marked other than "natural", or Itams 23a or 28a-f show traumatic event, Its Medical Examinat must be notilied at 1 ☐ Yes 2 No Director CHARALARD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 -S.A. 2951 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2-£ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after conent of Health and Mental Hygiene. Int: If item 27 is marked other then "natural", or Iter 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) JOS- A. BAI 3485 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be A20) ORAZIO Ladoviba 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) LARYLAND permit. Pages 1 and Department of Health Important: If item 27 any injury or othar tr <u>once</u>. Anna O(ZIERP 212,34 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 10. ₩ Burial 2 Cremation 3 Removal from State SENSEOS) KLOK CALTIMORE 4 □ Donation 5 □ Other (Speqify) 3007 21. Igne 17 L Fun ral Service Lic wisee 22. Name and Address of Facility (117) EVANS LYCHALDE (127) 8800 HARFORO ROAD 12mgrils 1287750 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Demoutla disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, bearing to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to for as a consequence of: Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown signed by to be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Tyes 2. No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 25 No 1 Yes Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 2**/2** No 2 1 TYes 1 Inpatient 2 ER/Outpatient 3 DOA this Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 3 Suicide 6 Could not be determined 2Be. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 29a. Certifier rth Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) within 24 and manner stated. 11 CHAZL 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0039297 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21234 10 MO 5 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

			State of Maryland / Dep	artment of Health and Mertificate of Death		ne 004	39106				
			Decedent's Name (First, Middle, Last)		2. Date of Death	.110.	3. Time of Death				
	Physicia /Medic		KATHERINE E. DAILEY	,	December	08,2004	12:32 a M				
	Examin	er	4a. Facility Name (If not institution, give street and number)  Anne Arundel Medical Ceneter	4b. City, Town, or Location of Death Annapolis		4c. County of Deat					
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	-	8. Date of Birth		hplace (State or Foreign ountry) y Land				
L	Director		217-56-2543 1 ☐ M 2 M F 94 Yrs.  Usual Residence of Decedent	Monte Bayo House Min.	June 02,	1910   Mar	ÿľánd				
	show		10a. State 10b. County 10c. City, Town or L				10d. Inside City Limits				
	Be-f sl	ctor		Pasadena			1 ☐ Yes 2 🛣 No				
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examination usited at once.	Funeral Director	10e. Street and Number 8552 Main Avenue	10f. Zip Code 21122	10g	U.S.A.	untry?				
	ems 2	ınera	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White					
0000	irs afte	by Fi	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 例 No If Yes, Give 3 1 ☑ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: Wh					
5	72 hou natura jical E		(Specify only highest grade completed) (Give	edent's Usual Occupation a kind of work done during most of workir	16	b. Kind of Business/	Industry				
7	within ene. than "	Completed	Flementany/Secondary (0-12) College (1-4or 5-)	DO NOT use retired) Iomemaker		Home					
ב ב	e filed Il Hygid Other	0	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Ma	iden Sumame)					
yland	ould by Menta	To B	John J. Gill	Catheri		Sheehan					
<u> </u>	and 2 sh ealth and n 27 is m			ing Address (Street and Number or Rura. D Riverside Drive,							
e,	as 1 ar of Hea of Hea itam		20a. Method of Disposition 20b. Place of Disp			c. Location - City or					
Dallimor	ment of the tant: If its		`4 □Donation 5 □Other (Specify) Glen Hav	en Mem Park 12-10	-04 G	len Burni	e,Maryland				
<u>0</u>	permit. Departn Imports any inju		21. Signature of Funeral Service Licensee McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122								
			23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between								
	Physician /Medical		Intrinediate Cause (Final disease or condition resulting in death)	a metesty 1	ri		Onset and Death				
	Examiner		Due to (or as a consequence of):								
	ed sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
` 	icate be executed physician and s the burial-transit	Examiner	resulting in death) Last  Due to (or as a consequence of):								
0/00	ate be	dical	d								
O XO	certific nding p	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant			23d. Date of deli	iverv				
0	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months?  1  Yes 2 No 4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		Month Day Year					
л Э	that the	Phy	9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the u	23e. Did tobac	23e. Did tobacco use contribute to the cause of death?						
ecords,	quires n signe	ed by	Serile Nementa	1 ☐ Yes	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown						
ဝပ	law relas bee	ompleted			24a. Was an autopsy	prior to d	topsy findings available completion of cause of				
<u> </u>		O				d? death? 1 ☐ Yes	2 <del>2 N</del> o				
VIII	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2☐ NO Hospital: 1☐ Inpatient 2 ☐ ER/Outpatie	26. Place of Death		e 6 □Other (Spec	city)				
Ö	ing Phys Itter this Ineral di	lon: T	27. Manner of Death 1. Natural 5 Pending (Month, Day Year) Injury	of 28c. Injury at Work? 2	8d. Describe how						
DIVISION	uttendi death. ctor: A y the fu	ertificat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st	M 1 Yes 2 No	8f. Location (Stree	at and Number or Ru	ral Route Number.				
2	s after al Dira	Certi	4 Homicide determined building, etc. (Specify)		City or Town, S	State)					
	To the Hospital or Attending Ph within 24 hours after death. To the Funaral Diractor: After the completely filled in by the funeral	Medical (	29a. Certifier  (Check only one)  Check only one)  Certifying Physician: To the best of my knowledge, dea 2 Medicel Exeminer: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, a nvestigation, in my opinion, death occurre	and due to the caused at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)				
	To the within To the comple	Me	29b. Signature and title of certifier	29c. License number	29d	Date signed (Month	n, Day, Year)				
			1 in U	10057635	1	Dec 08	2004				
	3		30. Name and address of person who completed cause of death (Item 23a) (Type	POOS 7635 Arland Anraga	t mm	21461					
\$1 P <sup>2</sup>	Sta		31. Date filed (Month, Day, Year)  OFC 1 0 2004  Separation of the Michael Company of the M	Some Sal	113 11112	6-11-1					
	Registr	ar	DEC 1 0 2004	mound							

ORIGINAL

DHMH 17 Rev 1/2001

DAVENPORT

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

-7	893		State of Maryland 1- State Unpend Item 23a, pt.II,27 per	l / Depa	artment of He	aith and M	lental Hyg	iene	
			1 - State Unpend Item 23a, pt.11,2/ per Registrar  1. Decedent's Name (First, Middle, Last)	r meer	tificate of B	eaths	2. Date of Deal		3 Time of Death
	Physici	an DEFICION I DAVENPORT DECEMBED 7 200/. 11.5						11:52a M	
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or L			4c. County of Dea	
			2016 HARLEM AVENUE			ORE CITY		N,	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. Ia:	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		rthplace (State or Foreign country)
	Director		212-44-6324 58 Usual Residence of Decedent				10-31-1	946	MD
	nylanc how	Director		Town or Lo					10d. Inside City Limits
	8a-fs			BALTI					MYes 2 □ No
	with the or 2	Dire	10e. Street and Number		10f. Zip Code		1	0g. Citizen of What C	-
	ns 23	Funeral	2016 HARLEM AVENUE  11. Marital Status  12. Was Decedent Ever in U.S.	.   13. \		1217 panic Origin? (Spe	acify Yes or No-	USA 14. Race - Am	
	after d	Fun	1 ☐ Never Married 2 ☐ X Married 1 ☐ Yes 2 X No		Was Decedent of Hisp I Yes, specify Cuban,		Rican, etc.)	Black, Wh	ite, etc.
9	urel', c	To Be Completed by	3 Widowed 4 Divorced If Yes, Give Year or Dates:		1 ☐ Yes 27 No	Specify:		Specify: B]	LACK
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. id other then "neturel", or items 23e or 28e-f show event, I'm Medical Erania withmetter netified at		15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupati kind of work done du DO NOT use retired)	io <b>n</b> Iring most of work	ing	16b. Kind of Business	s/Industry
12	within iene. then		Elementary/Secondary (0-12) College (1-4or 5+)		ORER			HOME IMPRO	VEMENT
פ	e filed al Hygi other vent, L		17. Father's Name (First, Middle, Last)	1111		8. Mother's Name			
Maryland			JAMES EDWARD DAVENPORT			CATHI	ERINE	JOHNSON	
Jar	s t and 2 should Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print)  JOHN E. DAVENPORT/BROTHER					City or Town, State,	
	1 and Health em 27 ther t		20a Method of Disposition 20b. Pla	ce of Dispo:	sition (Name of			E, MD 2121 20c. Location - City of	
פֿר	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other once.		1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State	metery, cren MEM •	matory`or other place)  DIV	12/14		ALTIMORE,	
Baltimore,	mit. F partme porter r injur		21. Signature of Funeral Service Licensee					RTON & SON	
m	Depa Impo any ir		Annes a. Worten					O., MD 212	
			23a. Fant. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not ente	er the mode of dying,	such as cardiac o	or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)  a.Atheroscleroti	ic Car	diovascula	ar Disea	se		Onset and Death
	/Medical Examiner		Due to (or as a conseque	ence of):					
h		er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):						
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events						
Ŏ,	ate be executed hysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):						
8760	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical	d						
9 ×	eath certific attending p	/Me	IF FEMALE: 23c. If yes, outcome of pregnance	cy				23d. Date of de	liven
Вох	death a atter d for u	Completed by Physician/Med	23b. Was decedent pregnant in the past 12 months?  1   Yes 2   No 4   Pregnant at time of dea		Ectopic pregnancy Other (specify)			Month	Day Year
0.	at the de by the a stached		9 Unknown				_		
	w requires that been signed b should be deta		Part II. Other significant conditions contributing to death but not result	-	nderlying cause given	in Part I.		_	o the cause of death?
ord	requir		Chronic Narcotism And Alcoholism	1			1 □ Ye	s 2□No 3□P	robably 4 Nunknown
Records,	has by	mpl					24a. Was an autops	y prior to	utopsy findings available completion of cause of
	sicien: The law s certificate has b lirector, page 2 s	e Co	25. Was case referred to medical			OC Disease of Death	1X Yes 2	No 18 Yes	s 2 No
5	ysicie Is cert directi	To B	examiner?	R/Outpatien	Othor	26. Place of Death  4 □ Nursing Hor		nce 6XX ther (Spe	ecity SCENE
Division of Vital	ding Phy h. After thi funeral		27. Manner of Death 1 Matural 5 ☐ Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury a Work?			w injury occurred	,,,
SIO	Attendir er death. rector: Al by the fu	catle	2 Accident investigation		M 1 Ye	s 2□No			
$\leq$	l or Atten after deat Director: I in by the	Certification:	4 Homicide determined 28e. Place of Injury - At hom building, etc. (Specify)	ie, farm, stre	eet, factory, office		28f. Location (St City or Town	eet and Number or R , State)	ural Route Number,
	spitel		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific; completely filled in by the funeral director.	Medical	(Check only one) Medical Examiner: On the best of my known and manner stated.	on and/or inv	vestigation, in my opir	nion, death occurr	ed at the time, da	ite and place, and du	e to the cause(s)
		Z	29b. Signature and title of certifier		29c. License :	number		Od. Date signed (Mon.) ECEMBER 8,	
	Order		P Ump C					JULIULIK 0,	2007
1	Derice		30. Name and address of person who completed cause of death (Item 2	23a) (Type, 1 111	Print) L PENN STR	EET, BAL	TIMORE,	MARYLAND :	21201
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signatu	ire ,	,		-		
	Registr	aŗ	DEC 1 0 2004 Seneral	B	Spark	<i>}</i>			

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O O I

			1 - For State Registrar	State of Ma	arytand / Depa <i>Ce</i> :	artment of H <i>rtificate of l</i>	leaith and iv D <i>eath</i>		2004	39109
	Physici	. n	1. Decedent's Name (First, Mid	ldle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Michael John C					December	8, 2004	2:45 p M
	Examin	er	4a. Facility Name (If not institute 431 Schwartz A				Location of Death		4c. County of Dea	
	Francis		5. Social Security Number		e (In yrs. last birthday)		altimore    If Under 24 Hrs.	8. Date of Birth	Baltimore 9. Bir	
	Funeral Director		218-46-8457 Usual Residence of Decedent	1 <b>⊠</b> M 2□F	56 Yrs.	Months Days	Hours Min.	(Month, Day, ) Feb 14,	(ear) Co	thplace (State or Foreign country) sachusetts
	yland		10a. State 10b. Coun	ity	10c. City, Town or Lo	ocation				10d. Inside City Limits
	e Mar la-t sh	ctor	MD Balt:	imore	Baltimore	2				1 □Yes 2 No
	or 28	Dire	10e. Street and Number			10f. Zip Code		100	g. Citizen of What Co	ountry?
	s 23a	eral	431Schwartz Av		Fire is II S 40	21212			nited Stat	
	ter de	Funeral Director	11. Marital Status 1 ☑ Never Married 2 ☐ Ma	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
980	ursal	by	3 ☐ Widowed 4 ☐ Divorce	If Yes Give	7-69	1 ☐ Yes 2 No	Specify:		Specify: Whit	e
5-0	72 ho	eted		lent's Education hest grade completed)	16a. Dece	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of work	ing 16	b. Kind of Business	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland lat Hyglene. d other than "natural", or Itams 23a or 28a-t show event, the Medical Exerting that the colling of	Completed	Elementary/Secondary (0-12)		5+) Carpe		)	Ur	nion	
9	Hygie Hygie othar		17. Father's Name (First, Middle		carpe	ITCCI	18. Mother's Name	e (First, Middle, Ma	uiden Sumame)	
lan	Med contail	To Be	Joseph Croke				Rita Huc	ke		
ary	shou s mar sumat	_	19a. Informant's Name/Relation	nship (Type, Print)	19b. Maili	ng Address (Street a	and Number or Rura	al Route Number, (	City or Town, State,	Zip Code)
	and 2 ealth n 27 i		Ms. Margaret C	onner/Sister					MD 21212	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: It item 27 is merked other than "natural", or Itams 23a or 28a-1 show any injury or other traumatic event, Ita Medical Examinating 181 to 1 williand at Once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other	n 3 Removal from State (Specify)	20b. Place of Disponsion Chesapeal	osition <i>(Name of</i> matory or other plac ke Cremate	.	ec 9	c.Location-City or eltsville,	
Balt	permit. Departr Importe any inj		21. Signature of Funeral Service	Hull !		2. Name and Addres Cremation 3717 Green			natives Baltimore	e, MD
			23a. Part1. Enter the disease, shock, or heart failure. Li	or complications that caused ist only one cause on each li	the death. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory arres	t,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	CA	NCER OF	= LIVER				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	NCFR OF a consequence of): RRHOSIC O7	- INER				
		<u>-</u>	Sequentially list conditions, if any leading to immediate		a consequence of):	- LIVER				
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1						
oʻ	an an	Exa	resulting in death) Last	C Due to (or as	a consequence of);			•		
68760,	tificate be executed g physician and as the burial-transit	edical		d						
	certific nding p		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of de	livery
.O. Box	es that the death cei igned by the attendir be detached for use	Physician/M	in the past 12 months? 1 Yes 2 No 9 Unknown	1 □Live birth 4 □ Pregnant at 9 □ Unknown		□Ectopic pregnancy □ Other (specify)			Month	Day Year
<u>α</u>	s that ined b e deta	by Pr	Part II. Other significant condi	itions contributing to death b	out not resulting in the u	ınderlying cause give	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ğ	w require been sig should b							1 ☐ Yes	2 M No 3 □ P	robably 4 Unknown
Vital Records,	e la has	Completed						24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
ital		BeC	25. Was case referred to medic examiner?					(Check only one)		
of V	Physician: this certific ral director,	2	1 ☐ Yes 2 ☐ No		ent 2 ER/Outpatier	nt 3 DOA Othe	er: 4 🗆 Nursing Ho		ce 6 □Other (Spe	cify)
on c	ding Physician: h. After this certific funeral director,	lon	27. Manner of Death 1 ☑ Natural 5 ☐ Pend		y Year) 28b. Time o Injury	Work		28d. Describe how	injury occurred	
Division	Attending r death. actor: After by the funer	ficat	3 ☐ Suicide 6 ☐ Coul		ury - At home, farm, st			28f. Location (Stre	et and Number or R	ural Route Number.
<u>S</u>	after 1 Dira	Certification:	4  Homicide	building, et	c. (Specify)			City or Town,		
	To tha Hospitel or Attend within 24 hours after death To tha Funaral Diractor: completely filled in by the	edical C	29a. Certifier 1 Certify (Check only one)	ying Physician: To the best al Examiner: On the basis o and manner st	if examination and/or in	th occurred at the tim rvestigation, in my of	ne, date and place, pinion, death occurr	and due to the cau red at the time, date	se(s) and manner as and place, and due	s stated. e to the cause(s)
	To tha I within 2. To tha I complet	₩ Me	29b. Signature and title of certification	ifies-		29c. License		290	. Date signed (Mont	h, Day, Year)
ì	,		> cunjani				16619		ecember	
'	Ke		30. Name an laddr ss of person C-VERGARA - S.	on who completed cause of down who cause	death (Item 23a) (Type, OFRANKUM ar's Signature	Print)  SQUERE	DRIVE	BALTIN	MORE, MI	0.21236
	Sta Registr		31. Date filed (Month, Day, Yea DEC 1	0 2004 32. Redistr	ar's Signature	pour				

		i	1 - For State Registrar		State of M	aryland / D )	epartment of I Certificate of	lealth and N <i>Death</i>		jiene200	14 3911	0
	Physici /Medic		Decedent's Name (First, Johan		err				2. Date of Dea Month December	Day	Year 3:30 P	
	Examin Funeral Director		4a. Facility Name (If not in:  Manor Care— 5. Social Security Number 577-78-0945	Potoma 6. Se	c	e (In yrs. last birth 79 Y	Potoma		8. Date of Birth (Month, Day March 15	4c. County o Montgo Year) , 1925		sign
	aryland ehow	ار	Usual Residence of Deced	County		10c. City, Town					10d, Inside City Lim 1-√2 Yes 2 ☐ I	
	with the Mi 3a or 28a-f	Funeral Director	Maryland Mo 10e. Street and Number 410 Summer	ntgome Garde		Rockv	111e 10f. Zip Code 20850		1	Og. Citizen of Wi	hat Country?	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "natural, or itema 23a or 28a-f ehow other traumatic event, it a Medical Examinar man be multipled at	by Funera	11. Marital Status  1 □ Never Married 2[ 3 ⅓ Widowed 4 □ Dr	1.00	12. Was Decedent Armed Forces? 1 ☐ Yes 2 3 If Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☒ No		ecify Yes or No- Rican, etc.)	Black	- American Indian, , White, etc. White	
21215-0036	within 72 hou lene. then *natura te Medical E	Completed	15. De	ecedent's Edu highest grad		5+)	Decedent's Usual Occup Give kind of work done life. DO NOT use retire	pation during most of work d)	ing	16b. Kind of Bus		
Maryland 2	iould be filed within Mental Hygiene.  Parked other then patic event, I.a.M.	To Be Co	17. Father's Name (First, M Franciszek		anovsky		Homemaker	18. Mother's Nam		Own Ho Maiden Sumame koviak		
	i and 2 should Health and Men em 27 is marketthan traumatic		19a. Informant's Name/Re Kataneh M.			1	Mailing Address <i>(Street</i> ) Summer Ga					
Baltimore,	Page nent c		20a. Method of Disposition 1 ⊠ Burial 2 ☐ Crem 1 ☐ Donation 5 ☐ O	nation 3 🗆 l		cemetery	Disposition (Name of crematory or other plain reek Cemete	ce) Decer ery 20	mber 11 <b>,</b> 004	Washingt	City or Town, State	
Ball	permit. Pa Departmer important any injury once.		21. Signature of Funeral S	OBR	ins	M01356	Rockville Rockville	; Inc. 300 Maryland	1 26850 <sup>M</sup>	2085 omer		e/
68760,	Physician: The law requires that the death certificate be executed was been signed by the attending physician and upon related director, page 2 should be detached for use as the burial-transit	edicai Examiner	23a. Part1. Enter the dise shock, or heart failur Immediate Cause (Final disease or condition resulting in death)  Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e. List only o	a. Pneum Due to (or as b. Sepsi Due to (or as Pre-R	ne.  Aonia a consequence of a consequence of enal Azo a consequence of	): temia	ng, such as calidae	о техриацију атг	531,	Approximate Interval Between Onset and Death	
P.O. Box 6	the death certific y the attending p ched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregn in the past 12 months 1 □ Yes 2 ☒No 9 □ Unknown	ant	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 ☐ Ectopic pregnance 5 ☐ Other (specify) _	y		23d. Date Mont		
	quires that the de in signed by the a uld be detached f	by	Part II. Other significant o		ntributing to death b	ut not resulting in	the underlying cause gr	ven in Part I.			oute to the cause of death? B□ Probably 4 ᡌUnknow	
of Vital Records,	: The law requir cate has been si page 2 should	Completed	Hypothyr	oidism	1				24a. Was a autops perform	ned? de	ere autopsy findings availat for to completion of cause of tath? Yes 2 \( \) No	ble of
ion of Vita	ding After fune	ation; To Be	2 Accident	Pending investigation	Hospital: 1 ☐ Inpati 28a. Date of Inju (Month, Da	ry 28b. Ti	me of 28c. Injury		me 5 Reside	ence 6 Other		
Division	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical Certification;		Could not be determined	28e. Place of In building, et	ury - At home, farr c. (Specify)	n, street, factory, office		28f. Location (St City or Town		r or Rural Route Number,	
	To the Hospital or within 24 hours affe to the Funeral Dir completely filled in	Aedical	(Check only 2 M	edical Exam	sician: To the best iner: On the basis o and manner st	f examination and	death occurred at the til	ppinion, death occur	ed at the time, di	ate and place, an	nd due to the cause(s)	
	Viti	4	29b. Signature and title of	t'		3 M.,	4 2	0274		ecember	(Month, Day, Year) 5, 2004	
	5		30. Name and address of Kirti Vohra	a, M.D.	, 7710 Bi	adley Bl		sda, Mary	land 208	17		
10	Sta Registi		31. Date filed (Month, Day		32. Redistr	ar's Signature	& Sport	n				

DHMH 17 Rev 1/2001

		Ragistrachmenn TTEM #1 PER	of Maryland / Depart PER_RB& PHY_C839_1 <i>[2</i> 1]	ment of Health and	Mental Hygier		39111
Dhuaiai		1. Decedent's Name (First, Middle, Last) ANGEL	IA EVERNHAM /		2. Date of Death Month	Day Year	3. Time of Death
Physicia /Medic		Axaelia	CURRNHO	<del>-                                      </del>	NOV &	9 2001	12:00A.M
Examin		4a. Facility Name (I) not institution, give street and n	number) 4t	o. City, Town, or Location of Dea	th 4	4c. County of Death	
		Genesis- Frankli	1 words	Mosedale		DALTIM	
Funeral		5. Social Security Number 6. Sex	3- ()	Under Year If Under 24 Hrs onths Days Hours Min		9. Birthp	nlace (State or Foreign
Director		Usual Residence of Decedent	8/ 115.		17-1-03	1/60	U YORK
land		10a. State 10b. County	10c. City, Town or Locati	on		1	0d. Inside City Limits
Marylan f show	ğ	MD BALTIMORE	- PM	TIMORE			1 Tes 2 No
the 288	rec.	10e. Street and Number		10f. Zip Code	10g. (	Citizen of What Cour	ntry?
30 O	Funeral Director	JOIN Harford Re	√.	21224		1754	
deati ms 2	nerg	11. Marital Status 12. Was De	ecedent Ever in U.S. 13. Was	s Decedent of Hispanic Origin? (Ses, specify Cuban, Mexican, Puel	Specify Yes or No-	14. Race - Americ	
or Its			s 2 NVNo	Yes 22 No Specify:	to Rican, etc.)	Black, White,	etc.
If it Z   Z   23-0030  be filed within 72 hours after death with the Maryland  the Hygiene.  d other than "natural", or items 23e or 28e-f show  event. Ite Medical Examinar must be inclined at	d by	3	Dates:	Tes Epito Specify.		Specify: W	7,4,
72 h 72 h 72 h	Completed	15. Decedent's Education (Specify only highest grade completed	d) (Give kind	t's Usual Occupation d of work done during most of wo	orking 16b.	Kind of Business/Inc	dustry
within ene. than	dm	Elementary/Secondary (0-12) College	(1-4or 5+)	NOT use retired)		+ b. a.	
Iled v Hygie Hygie Iher t		17. Father's Name (First, Middle, Last)	nome		me (First, Middle, Maid	1 / JOI )C	
Id be tiled ental Hygi ked other ic event.	Be	Programme Const		T	1. 1 /		
at yidiliu ZIZI3-0030 should be tiled within 72 hours after death with the M Mantal Hygiene. nnarked other than "naturel", or Items 23e or 28e-f umatic event. The Wedical Evan Instrumit te ivoilita	۵	19a. Informant's Name/Relationship (Type, Print)	19b Mailing A	Address (Street and Number or R	ONING (	V or Town State Zin	Code)
Mar id 2 sh ith and ith and treum treum		N	1.010	OH Muc Bo	weekle is I	1 1/ 1/ 2/	0
Definition (e.), Mad yield ZIZIO-0000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mandal Hygiens Importent: I filem 27 is marked other than "naturel", or litems 23e or 28e-f show any injury or other treumatic event. It a Medical Examiner must be invitined at once.		20a. Method of Disposition	20b. Place of Disposition	on (Name of	Date 20c.	Location - City or To	own, State
Deficiency of the particular of mportent: If it in y injury or one of the particular or one of t		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	m State cemetery, cremato	DEL AHPC I	Worl F	10 = 5 - L	411 MD
Dalltill permit. Pa Departmen Importent: any injury		21. Signature of Funeral Service Licensee	22. N	SAACHAPIC+121 ame and Address of Facility BILD MCR	6709, 7C		III, MES
Dant permit. Departi Import any inj		Kun 1000 () 3	at Elle	BILLIMOR		D S CO HAKI	=000000
		23a. Part1. Enter the riseas of complications that	caused the death. Do not enter the			BAUCHHICI	Approximate
Dhusisian		shock, or heart failure. List only one call se or Immediate Cause (Final	•	1			Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)  a	o (or as a consequence of):	HRRY Im	1100		10 MIN
Examiner			ATTIC	ma louns			ZOIR
7	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	o (or as a consequence of):				,
outed nd ransi	Examiner	that initiated events					10
e exe ian a urial-t	Ë	resulting in death) Last Due t	o (or as a consequence of):				
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artific ing pl	Mec	IF FEMALE:					
ath cer	Physician/Me	23b. Was decedent pregnant 12styles 1		topic pregnancy		23d. Date of delive Month	ery Day Year
the a	/slc	1 ☐ Yes 2 Ø No 9 ☐ Unknown 9 ☐ Unknown		her (specify)			
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has has	mpl				24a. Was an autopsy performed?	prior to cor	psy findings available inpletion of cause of
	O				1□ Yes		2 No
VIIAI NEC ysicien: The law is certificate has b director, page 2 si	o Be	25. Was case referred to medical examiner?  1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \) Hospital:	7 Inneticat 0 7 50/0 to the control	Other	ath (Check only one)	6 Flore (0)	
a this	Η.	27. Manner of eath 28a. Dat	te of Injury 28b. Time of	28c. Injury at	Home 5 Residence 28d. Describe how in		/)
ding th: Afte	tlor	Natural 5 ☐ Pending (Mo	onth, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No			
r Attanding for death. rector: Afte	ifica	3 Suicide 6 Could not be determined 28e. Pla	ce of Injury - At home, farm, street,	factory, office	28f. Location (Street		I Route Number,
a after	Certification:	4 Homicide determined but	Iding, etc. (Specify)		City or Town, Sta	110)	
psplt hours inere	al	29a. Certifier (Certifying Physician: To t	he best of my knowledge, death oc	curred at the time, date and place	e, and due to the cause	(s) and manner as st	ated.
To the Hospitel or Attanding Physicien: within 24 hours after death To the Funerel Director: After this certific completely lilled in by the funeral director,	edical	(Check only 2 Medical Examiner: On the one) and ma	basis of examination and/or invest anner stated.	ugation, in my opinion, death occ	urred at the time, date a	nu place, and due to	tne cause(s)
To t Withi To t	Z	29b. Signature and title of certifier		29c. License number	29d. [	Date signed (Month,	Day, Year)
		· / Cuy	$\propto$	7460,	1 1	2/6/04	
1		30. Name and address of person who completed ca	use of death (Item 23a) (Type, Prin		2		
		Michael Suter 45/2 31. Date filed (Month, Day, Year) 32.	TOKOLOKO, FF	4 DALTMON	E MB 2	1234	
Sta Registr		DEC 1 0 2004	Deput a Signature	spale			

Beverly Mae Fenner

Please Type or Print in Black	k Indelible Ink. Ensure All	Copies Are Legible.		
State of Maryland / D	Department of Health and Me Certificate of Death	ental Hygiene 00 L	3911	6
lame (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death	

		For	State of Maryland	/ Department of Health and I	Mental Hygien	enni.	20112
		1 - State Registrar		Certificate of Death	Reg. N	2 0 0 tj	23115
		1. Decedent's Name (First, Middle	, Last)		2, Date of Death Month D	ay Year	3. Time of Death
	sician edical		1 M FE	ENNER	December	06,2004	09:45AM
	miner	A - C - We have a Min - A in a standard	give street and number)	4b. City, Town, or Location of Death	n 4	c. County of Death	
		GOOD SUMARI	tan Hospital	Pal timore		NA	
Fune	ral	5. Social Security Number	6. Sex 7. Age (In yrs. las	t birthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yea,	9. Birthpl	lace (State or Foreign try)
Direct		214-74-3604	10 M 2/0 F	Yrs.	AUG. 23.19	154 MA	RYLAND
p .		Usual Residence of Decedent  10a. State 10b. County	10a City	Fown or Location	/	41	Od. Inside City Limits
anylan			,	Daniel Education	-1		18€ Yes 2 □ No
ours after death with the Maryla ral', or Items 23a or 28a-f shor	Funeral Director	MARYLAND WA	LTIMORE	ARRVILL	E		
or 2	Dire	10e. Street and Number	. 1	10f. Zip Code	10g. C	Citizen of What Coun	try?
ath v	i e	44 METE	OR COURT	2/23	7	USA	1
er dea Items	eun	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - America Black, White, e	
s afte	by F	1 Never Married 2 Marri 3 Widowed 4 Divorced	If Yes, Give	1 ☐ Yes 2 ☑ No Specify:		Specify:	2011
		15. Decedent	Year or Dates:	16a Decadestic Heral Convention	165	Kind of Business/Ind	ACK
n 72	lete	(Specify only highes	t grade completed)	<ol> <li>Decedent's Usual Occupation (Give kind of work done during most of world life. DO NOT use retired)</li> </ol>	rking 186.	Killid of Business/illid	lustry
d 2 should be filed within 72 h th and Mental Hygiene. T? is marked other than "natu	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	HOMEMAKER		OWNH	tomE
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2 should be filed with and Mental Hygiene is marked other the	P	19a. Informan's Name/Relationsh		19b. Mailing Address (Street and Number or Ru		or Town, State, Zip	Code)
d 2 s d 2 s th an		THOAMASO	N (DAUGHTER)	44 METEOR CT.	PARKUN	15 40	11234
C = 64 F		20a. Method of Disposition	20b. Plac	ce of Disposition (Name of	Date 20c.	Location - City or To	wn, State
Pages nent of int: If its		1 Burial 2 □ Cremation	3 L. Removal from State	netery, crematory or other place)			A 44 O 00 4 4 - 10
it. P.		* 4 □ Donation 5 □ Other (Sp 21. Signature of Funeral Service I		ZION CEMETERY 12-1		NSDOWNE	MAKYLAND
permit. Pages 1 at Department of Hee Important: If itam	once	21. Signature of Pulleral Service to	1/1/1/2010	22. Name and Address of Facility	OUNTR.		
		On Part Fater the disease or	complications that caused the death	Do not enter the mode of dying, such as cardiac		BALTO, M.	Approximate
		shock, or heart failure. List	only one cause on each line.	Do not enter the mode or dying, such as cardiac	or respiratory arrest,		Interval Between Onset and Death
Physici		Immediate Cause (Final disease or condition resulting in death)	sepgis				
/Medio		resulting in death)	Due to (or as a consequer	nce of):			
LAGITI		Sequentially list conditions,	b				
ъ ÷	Fxaminer	if any, leading to immediate cause. Enter Unidentified Cause (Disease or injury	Due to (or as a consequer	nce or):			
ificate be executed physician and	8	that initiated events resulting in death) Last	c. Due to (or as a consequer	noo ofi			
Sian Sian			Due to (or as a consequen	nee org.			
ate b hysic	Polical		d				
2 500	<u> </u>	IF FEMALE:	20. 11				
attendin	2 /0	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnanc	eath 3 □Ectopic pregnancy		23d. Date of delive Month	ry Day Year
e de	hveician/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at time of deat	th 5 Other (specify)		1	,
that the death cered by the attending	Phy Q	Death Other cignificant condition	and contribution to death but notti	ing in the underlying cause given in Part I.	23a Did tabasas	use contribute to th	a cause of death?
res ti	3 5	Parti. Other significant condition	the contributing to death but not teaml	ing in the universitying cause given it rait I.		2 No 3 Proba	
w requires that is been signed.	4				1 1 195	2   NO 3   F1008	abiy 4 (MOTIKITOWI)
The law requires that the death cert is has been signed by the attending	age s single				24a. Was an autopsy	24b. Were autor prior to cor	osy findings available npletion of cause of
The law	6				performed?	death?	

Division of Vital

Be Co ို Certification;

25. Was case referred to medical examiner?

Medical

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p.

State Registrar

29b. Signature and title of certifier Nowhar, MD

5 Pending investigation

6 Could not be determined

29c. License number

28c. Injury at Work?

1 🗌 Yes

2 🗌 No

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Res 600

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

DECEMBER 7 2004 BIVd, Baltimore, MD 21239

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

och Raven 32. Registrar's Signature oaks

28b. Time of Injury

ROHINI NOYON A
31. Date filed (Month, Day, Year)
DEC 1 0 2004

1 ☐ Yes 2 ☐ No

27. Manner of Death

1 Matural

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

Hospital: 1 ☑Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28a. Date of Injury (Month, Day Year)

			For Stete	State of Mai		•	artment	of Hea	alth and		tal Hygie	ene	201	20	1.10
			Registrar			Cei	tificate	or De	aın	100		. No.	104	39	113
	Pĥysicia	an	1. Decedent's Name (First, Middle, Last	_	T	10100				l N	ate of Death Month	Day	Yeer	3. Time o	
	/Medic		Ronald	Earl	F	ales	41 O' T				12	7	2004	10:50	o r ···
	Examin	er	4a. Facility Name (If not institution, give	·	1	TEA		OWN, OF LOC ROSED	ation of De	ath			nty of Death	00E	
			FRANKLIN SQUARE  5. Social Security Number 6. Se			last birthday)	If Under 1		Under 24 H	rs. 8 D	ate of Birth	D			or Foreign
L	Funeral Director		215 34 8816	7.4 - 7 -	55	Yrs.				in. Ma	Month, Day, Y	1939	Mary	lace (State try) Land	or r oreign
	land ow		10a. State 10b. County	1	10c. Cit	y, Town or Lo	cation						1	0d. Inside C	City Limits
	Mary f sh	į	Maryland Baltimore	2		Essex								1 🖺 Yes	s 2 No
	r 28e	rec	10e. Street and Number				10f. Zip C	Code			100	. Citizen o	of What Cour		
	h with	O le	465 Torner Road					2	12221				USA		
	deat	Funeral Director	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U	.S. 13. \	Was Decede f Yes, specif	nt of Hispa	nic Origin?	(Specify	Yes or No-		ace - Americ		
9	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or Items 23e or 28e-f show event. The Medical Examinat must be rotified at	/Fu	1 ☐ Never Married 2 X Married	1 ☐ Yes 2 ☐ No		1	1 □ Yes 2[		pecify:	orto rilour	1, 010.7	Spe	-:£.,		
8	ural',	d by	3 Widowed 4 Divorced	Year or Dates:									MIIT		
5	natu	Completed	15. Decedent's Edu (Specify only highest grad	ucation le completed)		16a. Deced	dent's Usual <i>kind of work</i> DO NOT use	Occupation done durin	n ng most of v	working	16	b. Kind of	Business/Ind	lustry	
7	within	ш	Elementary/Secondary (0-12)	College (1-4or 5+	)		lder	retirea)			7	0200	Too ac		
22	Hygie ther nt.		17. Father's Name (First, Middle, Last)			AAT	Taer	18.	Mother's N	Name (Firs	st, Middle, Ma		Space		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumetic event. The Medical Examinar must be notified at once.	To Be	William Palmer						Grace	e R	hue				
	nd 2 shoalth and 27 is m		19a. Informant's Name/Relationship (T Shirley Fales (V	<sub>vpe, Print)</sub> vife)							ite Number, C .ryland			Code)	
re,	is 1 a of Heginton		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name	e of er place)	•	Date	20	c. Locatio	n - City or To	wn, State	
E	Page nent c int: If		1 ☐ Burial 2 🛣 Cremation 3 🔲 I  4 💭 Donation 5 🗀 Other (Specify,			view C			NC 12,	/9/04	Ba	ltimo	ore, M	arylar	nd
Baltimore,	permit. Departn Imports any inju		21. Sit lature of Funeral Selvice Licens	99	/	14	2. Name and	Address of	Facility Bi	ruzdz Avenu	inski e Esse	Fune:	cal Ho	ne PA 2122	1
	1 1		23a Part1. Enter the disease, or comp	lications that caused the	he deat								- y <del>L</del> aria	Approxima	ite
	Pnysician		shock, or heart failure. List only of Immediate Cause (Final diseas or condition	one cause on each line										Interval Be Onset and	Death
	/Medical		resulting in death)	a Due to (or as a	consea	uence of):					-				
	Examiner					,									
	110	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Clience or injury	b. Due to (or as a	conseq	uence of):									
	te be executed ysician and ne burial-transit	Examiner	that initiated events	C											
ó	an ar rial-ti		resulting in death) Last	Due to (or as a	conseq	uence of):									
3760,	icate be executed physician and s the burial-transit	cal		d											
89	ntifica ng ph e as ti	Med	IF FEMALE:												
Вох	tth ce tendi	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2			Ectopic pre	gnancy					Date of delive		Year
0	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it	Physician/Med	1 Yes 2 No	4∏Pregnant at ti 9∏Unknown	me of d	eath 5□	Other (spec	cify)					violiti.	Day	1001
٩.	that the	Ph	Part II. Other significant conditions co	ntributing to death but	not res	ulting in the u	nderhijng car	use civen in	Part I		23e. Did toba	CCO USA CC	ontribute to th	e cause of	death?
js,	signe	by	Parti. Other significant conditions (c	intributing to death but	1101 103	atting at the di	nderlying cat	236 g/V6/1 II.	raiti.	'			3 ☐ Prob		
0	v requir been s should	etec						-		-  -					
Records,	e 2 s	Completed								- 2	24a. Was an autopsy			osy findings npletion of a	
Ξ Ε		Co								1	performe	No	death? 1 ☐ Yes	2□ No	
Vital	ysician: The law is certificate has t director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:				Othor			eck only one)				
of	> 0 D	2	1 ☐ Yes 2 🕱 No 27. Manner of Death	28a. Date of Injury	100000	ER/Outpatien		Other:	4 🔲 Nursing		5 Residence Describe how			)	
	ing After une	tlon	1 Natural 5 ☐ Pending	(Month, Day		Injury	M	Work?	2 🗆 No	200. 1	263CHD6 HOW	injury occ	arred		
isi	tan leat lor: the	ical	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injur	v - At h	ome farm str			2 🗆	28f. L	ocation (Stree	et and Nu	mber or Rura	l Route Nuc	nher
Division	in Dir	Certification:	4 ☐ Homicide determined	building, etc.	(Specif	(y)	cot, radiory,	OIIIOO		- 7	City or Town,	State)		7100107701	
	Hospita 24 hours Funerel tely filled	edical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medicel Exem	vsicien: To the best of iner: On the basis of e	examina	owledge, death	n occurred at vestigation, in	t the time, o	date and pla on, death oc	ace, and d	ue to the cau the time, date	se(s) and a	manner as st e, and due to	ated. the cause(	s)
	thin 2 o the	Med	29b. Signature and title of certifier	and manner state	) )		29c.	License nu	mber	<u> </u>	29d	. Date sign	ned (Month,	Day, Year)	
1	wit To		· //. //.	the			R	ESOC	200			12 -	7-20	04	
	3		30. Name and address of person who d	ompleted cause of man	ath (Iten	n 23a) (Type	Print)						, 20	- 1	
	9			IADES	700	O FRAN	VKLIN	Saur	ARE I	RIVE	BALT BALT	TIMOR	E, MI	1212	37
•	Sta Registr		31. Date filed (Month, Day, Year) DEC 1 0 2004	ompleted cause of de	's Signa	ature									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 👂 🛭 🗓 👢 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 10:46P<sup>M</sup> Joseph A. Fonte 2004 December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Hospice Towson Baltimore I OWSOII

If Under 1 Year If Under 24 Hrs. Months Days Hours Min.

Months Days Hours Min. May 9, 193 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex **Funeral** Months 1⊠M 2□F Director 219-32-4654 68 Maryland DECEMBER Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Item 27 is marked other then "neturel", or Items 23s or 28e-f show other treumetic event, the Modical Examiliar must be maillied at 1 ☐ Yes 2X No Directo Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6013 Burnt Oak Road 21228 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: <u>ک</u> Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 10 Mill Wright Machinist Machinery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be ind Mental Samuel Francis Fonte Sarah Rose Serio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a. Importent: If Item 27 is eny injury or other treu <u>once.</u> Lisa Hillman (Daughter) 1265 Lancaster Drive Eldersburg, Maryland 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State <sup>¹</sup> 4 □Donation 5 □Other (Specify) New Cathedral Cem. 12-11-2004 Baltimore, Maryland 22. Name and Address of Facility
Witzke Funeral Home of Catonsville, Inc. 21. Signature of Emeral Service Licensee MO1290 1630 Edmondson Ave. Catonsville, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician esoy menth /Medical Due to (or as a confequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Under, in Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner signed by the attending physician and d be detached for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 No 1 Yes or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence Other (Specify)H05 PICE 1 ☐ Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Jean 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Natural Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation after deatl Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number December 8, 200x 6601 N. Charles Street 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N.A.Rile Towson, Md. 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

	1	For State Registrar		,	Cei	rtifica	te of i	lealth and Death	Wiemann	Reg. No		3911
		I. Decedent's Name (First, Middle, Las	st)						2. Date of D			3. Time of Death
Physician /Medical	_	Elaine Pickus E	riedman						Decem	ber 6	y 2004	9:08A N
Examiner		a. Fecility Name (If not institution, give	e street and numbe	er)		4b. City	, Town, or	r Location of Dea	th	4c	. County of Dea	th
		5014 Elsmere Ave	nue			Be	these	la .			Montgon	nery
Funeral	5	5. Social Security Number 6. S	ex 7.	Age (In yrs. I	last birthday)		r 1 Year	If Under 24 Hrs Hours Min		irth	9. Bir	thplace (State or Foreig
Director		484-24-4278	□M 2ĂF	78	Yrs.	Months	Days	Hours Min	Aug.	26 <b>,</b> ]		owa
D .	-	Jsual Residence of Decedent										
how		10a. State 10b. County		10c. City	y, Town or Lo	cation						10d. Inside City Limits
e Ma liffer	2	Maryland Montgom	ery	Bet	hesda							1 ☐ Yes 2 📉 No
with the Mar s or 28e-f si be notified	2	10e. Street and Number				10f. Z	ip Code			10g. Cit	izen of What Co	ountry?
th will be seen a seen	2	5014 Elsmere Aver	nue			20	814			Uni	ted Sta	tes
2 should be filed within 72 hours after death with the Maryland and Mantal Hygiene. Is marked other then "natural", or Items 23a or 28e-f show eumetic event. The Mcdical Examiner must be notified at To Be Completed by Funeral Director	<u> </u>	11, Marital Status	12. Was Decede Armed Force	nt Ever in U.	S. 13.	Was Dec	edent of H	ispanic Origin? (	Specify Yes or N	lo-	14. Race - Ame Black, Whit	
after or it		1 ☐ Never Married 2 X Married	1 ☐ Yes 2 If Yes, Give			1 ☐ Yes	-	Specify:	, , , , , , , , , , , , , , , , , , , ,		Specify:	
ours a		3 Widowed 4 Divorced	Year or Date	s:			- 24 . 10	ороспу.			Specify.	White
ed within 72 ho ygiene. ner then "natur. t, the Wodgal I.	Š	15. Decedent's Ed (Specify only highest gra	ducation de completed)		16a. Dece	kind of w	ork done	during most of wo	orkina	16b. K	ind of Business	/Industry
ithin	<u>.</u>	Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT	use retired	1)				
Agier the form	5		3		Нот	nemak	ter				wn Home	
tal High doth		<ol> <li>Father's Name (First, Middle, Last)</li> </ol>						18. Mother's Na	me (First, Middi	e, Maiden	Sumame)	
Ment Ment arked	2	Sam G. Pickus						Mildr	ed Levy			
short sand		19a. Informant's Name/Relationship (	Type, Print)		19b. Mailir	ng Addres	s (Street	and Number or A	lural Route Num	ber, City o	or Town, State, .	Zip Code)
as 1 and 2 of Health of litem 27 is r other tre		Lyman G. Friedma	ın/Husban					Avenue,	Bethesd	a, Ma	aryland	20814
of He of He item	2	20a. Method of Disposition		1 0	lace of Dispo	sition (Na	ame of other plac	(e) Doc	Date cember	20c. L	ocation - City or	Town, State
Pages nent of h ant: If ite		1 ☐ Burial 2 🖾 Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specification 5		ue Mon	tgome:	cy i	-	Dec	2004	Retl	necda 1	Maryland
그는 원생	F	21. Signale of Funeral Service Lice	66	Cre	22	Name	nd Addre	ss of Facility RC	hert A.	Pilmi	hrev Fi	meral Home
permij Depar Impor any ir		130:08	A 1411	. MÜÜ8	B6	thes	da-C	hevy Cha	ise, Inc	. 751	7 Wisco	onsin Avenu
		23a. Part1. Enter the disease, or com	plications that thus	sed the death								Approximate
Harris I		shock, or heart failure. List only Immediate Cause (Final										Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)				liova	scul.	ar Disea	se			Many Years
Examiner			Due to (or	as a consequ	uence of):							
		Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consequ	uence of):	-						
ed isit		cause (Disease or injury	540 (0)	40 4 00110041	a 61,00 01).							
executed an and rial-transit	Xa	that initiated events resulting in death) Last	c. Due to (or	as a consequ	uence of):	-						
cate be executed physician and the burial-transit			222.13 (3.									
physicia the bur	2		_ d									
that the death certific ed by the attending p detached for use as	U ~	IF FEMALE:	00-16									
The law requires that the death certify the has been signed by the attending cage 2 should be detached for use as completed by Physician/Me	a	23b. Was decedent pregnant in the past 12 months?		2 Fetal	Ideath 3□		oregnancy	,			23d. Date of de Month	livery Dav Year
he al	200	1 ☐ Yes 2 XNo	4□Pregnan 9□Unknow	t at time of de	eath 5	Other (s	pecify)		<del></del>		17103141	Day Tour
at the	= =											
es the good pe de de de de de		Part II. Other significant conditions of	_	n but not resi	uiting in the u	nderlying	cause givi	en in Part I.				the cause of death?
w requir been si should	<u> </u>	Cognitive Dysfun	ction						1	Yes 2	L¥No 3∐Pi	robably 4 Unknow
: The law requir cate has been s page 2 should	2								24a. Wa	s an	24b. Were at	topsy findings availab
The lay	5								per	formed? 2 🔲 No	death?	2 X No
		25. Was case referred to medical						26. Place of De	ath (Check only		13,00	
Physicien: this certificatal director,	ם	examiner? 1 XYes 2 No	Hospital:	atient 2 🗆	ER/Outpatier	nt 3 🗆 D	OA Oth		Home 5 X Re		6 □Other (Soe	cifu)
r thii		27. Manner of Death	28a. Date of I (Month,		28b. Time o		28c. Injun Wor		28d. Describe			o.iy)
ital or Attending Phrs after death. et Director: After the ied in by the funeral Cert Iffication: 7		1 XNatural 5 ☐ Pending 2 ☐ Accident investigation		Day Year)	Injury	М		k? Yes 2 ☐ No				
l or Attend after death Director: A in by the fi	20	3 ☐ Suicide 6 ☐ Could not b		Injury - At ho	ome, farm, str	eet, facto	rv. office					ural Route Number,
lor A after Directification by	2	4 Homicide	building,	etc. (Specif)	v)		,,		City or To	own, State	9)	
		29a. Certifier 1X Certifying Ph	ysician: To the be	ast of my kno	wiedge, deat	h occurre	d at the tin	ne, date and plac	e, and due to the	e cause(s	and manner as	stated
thin 24 hour thin 24 hour the Funer impletely fill	Ca	(Check only 2 Medical Exar	niner: On the basi	s of examina:	tion and/or in	vestigatio	n, in my o	pinion, death occ	urred at the time	, date and	place, and due	to the cause(s)
within to the comple	<u>ĕ</u> –	29b. Signature and title of of tifier	0 0	Jidiou.		29	oc. Licens	e number		29d. Da	te signed (Mont	h. Day. Year)
N 1 8 1	-		G Bux	w							9 (	,,/
. 1			-4				D378	40		Dec	ember 7	. 2004
<i>9</i>		30. Name and address of person who										
10		Brent A. Berger,	M.D. 1	0215 F	'ernwoo	d Ro	ad,	Suite 10	0, Beth	esda,	Maryla	nd 20817
State	е	31. Date filed (Month, Day, Year)	32. R/g	istrar's Signa	ture &	1	200					

DHMH 17 Rev 1/2001

		4	For State Registrar	State of M	aryland		artmeni rtificate					iene	n la	39116
	Physici		1. Decedent's Name (First, Middle,	ŕ							2. Date of Deat Month		Year	3. Time of Death
	/Medic	cal	Norman Gur  4a. Facility Name (If not institution,	iter			45 City	Tour or	Location of		Novembe		2004 ty of Death	3:35 AM
	Examir	ner	Johns Hopkins					Ltimo		or Death		40. Court	ly OI Death	
	Funeral Director		5. Social Security Number 227-01-3222		e (In yrs. la 88	a <i>st birthday)</i> Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, Jan 1,	1916	9. Birthp Cour V 1	olace (State or Foreign otry) Lrginia
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation						1	0d. Inside City Limits
	a-f sh	tor	MD Baltin	nore	Du	ndalk								1 ☐ Yes 2 ☐ No
	with the a or 28.	Dire	10e. Street and Number 7861 St. Clair	e Lane			10f. Zip	Code 21222	2		1	0g. Citizen of	What Cour	ntry?
936	be filed within 72 hours after death with the Maryland that Hygiene. Id other then "neturel", or Items 23a or 28a-f show event, I're Medical Examinar must be redified at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☒ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces?  1 XYes 2 If Yes, Give Year or Dates:	No 11-	7-41	Was Deced if Yes, spec	ify Cubar	spanic Ori n, Mexicar Specify:	i, Puerto I	ocify Yes or No- Rican, etc.)	14. Ra	ace - Americack, White,	
Maryland 21215-0036	c * 68	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or t	ō+)	life. I	dent's Usua kind of wor DO NOT us Guard	k done d	uring mos	t of worki	ng	16b. Kind of	Business/Ind	dustry
d 2	filed v Hygie other I		17. Father's Name (First, Middle, La	st)			Juaru		18. Mothe	er's Name	(First, Middle, M			=
/lan	should be filed within and Mental Hygiene. s marked other then umetic event, Ine M	To Be	Samuel Booker	Gunter					V	ergi	e Irene	Wrigh	t	
Mar	2 2 3 3 5 5 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6		19a. Informant's Name/Relationship Barbara Soles								<i>l R</i> oute Number, Carendor	-	o, State, Zip 28432	
ē,			20a. Method of Disposition		20b. Pl	ace of Dispo						20c. Location		
<u>E</u>	0 0		1  Burial 2  □ Cremation 3			ry Cen			1	1-26	-04	Richmo	ond, V	/A
Baltimore,	permit. Pag Department Importent: I eny injury o		21. Signature & Funeral Service Li	lloold	200	) 22	Blile P.O.				me chmond,	VA 2	3230	
L	Pnysician		23a. Part1 Enter the disease of construction in the condition resulting in death)	ity one cause on each li	ne.	Pneur		e of dying	j, such as	cardiac o	r respiratory arre	est,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as		•								
8760,	v ·š	Ical Examiner	Sequentially list conditions, if you have a mmonute cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Alzne Due to (or as	a cons⊎uu		c1a							
O. Box 6	The law requires that the death certificate be executed tte has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3	Ectopic pre						ate of delive	ry Day Year
<u>α</u>	quires that n signed b	by	Part II. Other significant condition Urinary Tract		ut not resu	lting in the ur	nderlying ca	ause give	n in Part I.					e cause of death?
Records,	The law requir ate has been si page 2 should I	Completed	Rhabdomyolysi	S							24a. Was ar autops perform 1 Yes 2	/	prior to con death?	psy findings available inpletion of cause of
Vital	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?							of Death	(Check only one			
of	Physi this c	2 1	1 ☐ Yes 2 XNo  27. Manner of Death	Hospital: 1 🔀 Inpatie		ER/Outpatien 28b. Time of			4 🗆 Nu		ne 5 Reside			"
on	th. : After this funeral of	tlon	1 XNatural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Da	y Year)	Injury	м	Bc. Injury Work 1 🔲 Y	? ′es 2 🔲 I		ou. Describe no	w injury occu	1160	
Division	of or Attending Physician: after death. I Director: After this certification by the funeral director.	Certification:	3 Suicide 6 Could no 4 Homicide determin		ury - At hor c. (Specify)	me, farm, str	eet, factory	, office		2	28f. Location (Str City or Town		ber or Rura	l Route Number,
	To the Hospitel or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certifying (Check only one)	Physician: To the best aminer: On the basis o and manner st	f examinati	vledge, death ion and/or inv	occurred a vestigation,	at the time in my op	e, date an inion, dea	d place, a th occurre	and due to the ca	use(s) and make and place,	anner as stand due to	ated. the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier				- 1	License				d. Date sign		Day, Year)
,	1	1	J. Nu	on completed serves of	path /lt	22a) (T		- 40	· r			)cc 10,	<b>3804</b>	
	M		30. Name ddress of person w	Johns	HOO/C	ins Be	ay vieu	s Me	dital	Cent	4			
	Sta Registi		31. Date filed (Month, Day, Year)  DEC 1 0 200	32. Registr			K)							

Eleanor Giorgilli 04-07767 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. crn Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death December 02, 2004 **Physician** bioRbithi 11:22 SIGNARLIS FRAMESS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center Baltimore N/A | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** HERITI 1 ☐ M 200 F Director 212-40-3387 TARYLAG Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or Items 23a or 28a-f show other treumatic event, if a Medical Examinar must be notified at Yes 2 □ No Directo SSOMITARD BRATARO 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code DOOWLELAH ZOGH V.S.A. 91909 death v Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after unent of Health and Mental Hygiene. Nnt: If item 27 is marked other than "natural", or Iter 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: If Yes, Give Year or Dates WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) AT HOME 134RS HOROMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be S. HARTKA SOWIN Artha.A ြ KTOZ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) FRANK V- GORBILL SOMITABLE SUA GOOGLESPAH ZOLF MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ↑ Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Importent: If any injury or once. ARKINOOO LEMETERY Sign war I Fund Service Licensee 4661B IARILAND 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Acute Diazepam And Ethanol intoxication /Medical Due to (or as a consequence of): **Examiner** Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Munknown been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) Found 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Unk 27. Manner of Death Certification: 1 Natural 5 Pending investigation Г8:28 Р 1 ☐ Yes 2 ₹ No 2 Accident Director: 2.2004 10:28 P 6 Could not be determined 3 🔲 Suicide 28f. Location (Street and Number of Bural Route Number, City or Town, State) 4605 HazeLwood Ave. 4 THomicide Scene Baltimore, Md

Medical

31. Date filed (Month, Day, Year) State DEC 1 0 2004 Registrar

29b. Signature and title of certifier

ANA

101

29a Certifier

RUBIO, MD 32. Fegistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

December 04, 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 15 per ft 838 12-16-04 yealth and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death DARRELL ZANE GOBEL. DECEMBER D. 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 201 9th STREET PASADENA If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, May 3, Birthptace (State or Foreign Country) 1 ☑ M 2 □ F 213-32-0401 70 Vrs Kentucky Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Pasadena 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 201 Ninth St., 21122 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 💆 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Education Professor -8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Albert J. Gobel, Sr. Gladys Griffith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanne M. Gobel (Wife) 201 Ninth St., Pasadena, Md. 21122 20b. Place of Disposition (Name of Glen Haven Mem. Pk. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 12/13/04 Glen Burnie, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee Kevin E Ecker 22. Name and Address of Facility

McCully-Polyniak Funeral Hom

any i

**Physician** 

/Medical

Examiner

**Funeral** 

Director

or items 23s or 28s-f show

Director

Funeral

by

Completed

Be

with the Maryland

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

**Physician** /Medical Examine

Department of Health Importent: If item 27

Division of Vital Records, P.O. Box 68760,

	23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused the death. Do one cause on each line.	o not enter the mode of dying, such as cardia	ac or respiratory arrest,	Approximate Interval Between
	Immediate Cause (Final disease or condition	METASTATIC H	PROSTATE CANCER		Onset and Death
	resulting in death)	Due to (or as a consequence			J 185
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. — Dus to (cr as a consequence	ı olj.		
	resulting in death) Last	Due to (or as a consequence	of):		
by rugsicial medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	h 3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
	Part II. Other significant conditions	contributing to death but not resulting	in the underlying cause given in Part I.		use contribute to the cause of death
Completed				24a. Was an autopsy performed?	24b. Were autopsy findings avail prior to completion of cause death?
ge	25. Was case referred to medical examiner?			eath (Check only one)	
9	1 ☐ Yes 2 🗙 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/O	utpatient 3 DOA Other: 4 Nursing	Home 5 sidence	6 ☐Other (Specify)
Ceruncation	27. Manner of Death  Natural 5 Pending 2 Accident investigatio	(Month, Day Year) n	Time of Injury at Work?  M 1 Yes 2 No	28d. Describe how inju	iry occurred
erune	3 Suicide 6 Could not be determined		arm, street, factory, office	28f. Location (Street a. City or Town, Stat	nd Number or Rural Route Number, e)
Medical C	29a. Certifier Check only one) Certifying Ph	nysician: To the best of my knowledg miner: On the basis of examination ar and manner stated.	ie, death occurred at the time, date and plac nd/or investigation, in my opinion, death occ	curred at the time, date an	s) and manner as stated. d place, and due to the cause(s)
	29b. Signature and title of certifier	$\wedge$	MO 29c. License number	ary and 29d. Da	ate signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

NANCY A. DAWSON, M.D.,

6004

31. Date filed (Month, Day, Year)

within 24 hours after or To the Funeral Direct completely filled in by

32. Registrar's Signature

Agad. Ar

22 .S. GREENE STREET, BALTIMORE, MARYLAND 21201

			For State Registrar	State of Maryla		artment of F			iene eg. No.20 (	) 4	391	19
ľ	Physici	an	Decedent's Name (First, Middle,     Robert	Last) Jack	Gund	lerman		2. Date of Dea Month Decembe	th Day	Year	3. Time of 3:00	Death a M
	/Medic		4a. Facility Name (If not institution,		- Odin		or Location of Dea		4c. County of		3.00	- a
8	Examin	er	1822 Quebec St			Sever			Anne A		e1	
	Funeral	A :-			. last birthday)	If Under 1 Year	If Under 24 Hr				ace (State or	r Foreign
н	Director		081-32-9604	1 <u>X</u> M 2□F 68	Yrs.	Months Days	Hours Mir	n. (Month, Day April 1		New_		
	<u> </u>		Usual Residence of Decedent					IIPITI I	, 1750	ITCW	TOTA	
	rylar		10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10	od. Inside Cit	
	8e-f	cto	MD Anne	Arundel	Severi	n					1 🗆 Yes	ZX_XNo
	ith th	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of W	hat Coun	try?	
	ath v	rai	1822 Quebec St			2114			USA			
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23s or 28e-1 show or other traumatic event, the Modical Exercities in 1911 by notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in N Armed Forces?  1 XYes 2 No If Yes, Give Year or Dates: Viet		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 📉 No		Specify Yes or No- erto Rican, etc.)		- America , White, e		
21215-0036	hour tural		15. Decedent			dent's Usual Occup	nation		16b. Kind of Bus	inges/Ind	uetni	
7	in 72	Completed	(Specify only highest	t grade completed)	(Give	kind of work done DO NOT use retire	during most of w	orking	TOD. Raile of Bas	MITO SS/IIIO	ustry	
12	iene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Opera	ations Ch	ief		U.S. Ar	mv		
D	e filed within at Hygiene. other than '	o l	17. Father's Name (First, Middle, L	ast)				ame (First, Middle, I				
Maryland	2 should be and Mental Is marked o raumatic eve	To B	John Gunderman					leline Per				
Ma	id 2 sh Ith and 27 Is r traur	11 3	19a. Informant's Name/Relationsh Inge Gunderman		1	_		Rum Route Number Severn, M	-	itate, ∠ip	Code)	
	1 an Heall em 2	1 3	20a. Method of Disposition				4		20c. Location - 0	City or To	wn. State	
Baltimore,	Pages nent of int: If it		1X Burial 2 Cremation	3 Linemoval II offi State		sition (Name of matory or other place				-		
ᆵ	# 문문을		' 4 ☐ Donation 5 ☐ Other (Sp 21. Signatu 3 f Funeral Service ✓			Vet. Cem		10/2004		тте,	MD	
Ba	permi Depa Impo any i		21. Signature 11 diletar Service	1001300	-21111245			L Home, P.				
	H <sub>2</sub>		23a. Part1. Inter the sease, or o	complications that caused the dea	ath. Do not ent			ie, Annapo		214	O1 Approximate	
b	- 15 A		s ock, or heart failure. List of Immediate sause (Fin II	inly one cause on each line.	O	^					Interval Betw Onset and D	reen
	Physician /Modical	7. 4	dise ise or condition resulting in death)	-a. Arteriose	lliota	- Carona	ing that	eny this	ase.		~7	
	/Medical Examiner			Due to (or as a conse	quence of):		1	1			2	
В		<u></u>	Sequentially list conditions,	b. Justo lo as a conse	mence of):	160					1	
	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	4	e 4 . So 20						7	
	xecurand and	xan	that initiated events resulting in death) Last	Due to (or as a conse	quence of);	<u> </u>				-		
8760,	icate be executed physician and s the burial-transit											
687	certificate be executed nding physician and use as the burial-transit	Physician/Medical		d								
	eath certifii attending p	/We	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr	nancy				23d. Date	of deliver	3/	
Вох	atter for u	ciar	in the past 12 months?	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of		Ectopic pregnancy  Other (specify)	/		Mont		<u> </u>	өаг
o.	that the do	ıysi	1 □ Yes 2 □ No 9 □ Unknown	9☐ Unknown		3 (4,555)/						
٩	requires that the een signed by th hould be detache		Part II. Other significant condition	ns contributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.	23e. Did tot	acco use contrib	oute to the	cause of de	ath?
sp.	uires sigr Ild be	d by						1 □ Ye	s 2 🗆 No 3	Proba	bly 4	nknown
of Vital Record	> 0 0	ompleted						24a. Was a	n 24h W	ere auton	sy findings a	vailable
Re	0 - 0	ш						autops	y pr ned2 de	or to com ath?	pletion of ca	use of
g	icien: Th certificate rector, pag	ပိ	25. Was case referred to medical				OC Diago of Do		7	Yes :	2 LI No	
>		00	examiner? 1 ☐ Yes 2 ☐ Xo	Hospital: 1 ☐ Inpatient 2 ☐	] ER/Outpatier	t 3 DOA Oth	0.0	Home 5 Seside		(Engaile)		
		1: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o			28d. Describe ho				
0	th. : After s funera	itioi	1 Natural 5 Pending 2 Accident investige		Injury		k? Yes 2∐No					
Division	or Attending after death. Director: After in by the fune	ertification;	3 ☐ Suicide 6 ☐ Could no	ned 286. Place of injury - At I	nome, farm, str	eet, factory, office		28f. Location (St.		or Rural	Route Numb	ner,
á	al or A after i Direct	erti	4 Homicide	building, etc. (Spec	ify)			City or Towr	i, State)			
	To the Hospital or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	edical C	(Check only 2 Medical 8	Physician: To the best of my kn examiner: On the basis of examin	owledge, deat ation and/or in	h occurred at the tir vestigation, in my o	me, date and place	ce, and due to the ca curred at the time, da	ause(s) and man	ner as sta	ted. the cause(s)	
	To the h within 24 To the 8 complete	Med	one)  29b. Signature and title of certifier	and manner stated.		29c. Licens			9d. Date signed			
	To To		255. Signature and title of certifier	8/1/ man								
F	1		your c	III mos		0	7 7 - 2	-4	OUCC	0	7	
	IVN		30. Name and address of person w	who completed cause of death (Ite Coffay MD	m 23a) (Туре,	Print)	2016	26 Ave Ft	Mer I.	_ bis	D 70	751-
	Sta	to		32. Registrar's Sign	iature - V	V	-00-700	TIVE IF	- wordt			TUD
	Sta Registr	ar	31. Date filed (Month, Day, Year) DEC 1 (	2004 32. Registrar's Sign	KA	book						

3			For State Registrar	State of Maryla	•	artment of H <i>tificate of I</i>			giene 0 0	4 39120
	ol.		Decedent's Name (First, Middle, Last,					2. Date of Dea	ath	3. Time of Death
	Physicia /Medic			Robert Lee	George 1	II		Decemb		004 1523p <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give Shock Trauma	street and number)		4b. City, Town, or Baltimo	r Location of Death Dre	1	4c. County of	
	Funeral Director		5. Social Security Number 6. Sec 159 56 8993	7. Age (In y	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Dec. 7,	, Year) 1975	9. Birthplace (State or Foreign Country) Pennsylvania
	pu k		Usual Residence of Decedent  10a. State 10b. County	100	City, Town or Lo	cation				10d. Inside City Limits
	Aaryla f shov	ō	Maryland N/A	100.	Baltimo					11X Yes 2 □ No
	r 28e-	rect	10e. Street and Number		24101110	10f. Zip Code			10g. Citizen of Wh	nat Country?
	th with	aiD	4148 Doris Avenu	e		2122	25		U.S.	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland ( Health and Mental Hygiene. Item 27 is marked other than "natural; or Iteme 23s or 28e-f show other treumatic event, its Medical Examinations in cities at	by Funeral Director	11. Marital Status  1 X Never Married 2 Married 3 Widowed 4 Divorced	12, Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	i	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		American Indian, White, etc. White
5-0	72 ho natur	eted	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Deced	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of wor	king	16b. Kind of Bus	iness/Industry
121	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		no not use retired hine Ope			Rock	Ouarry
	filed why hygie other family the		17. Father's Name (First, Middle, Last)					ne (First, Middle,	Maiden Sumame,	~
lan	ould be Mental arked o	To Be	Robert I	ee George J	r.		Car	cmen Holl	brook	
Maryland	2 should be filed withir and Mental Hygiene. is marked other than eumatic event, I'm M.		19a. Informant's Name/Relationship (T)	rpe, Print)		g Address (Street			-	
	fealth m 27 her tr		Craig Reinhart  20a. Method of Disposition	20	b. Place of Dispo	Doris Ave	enue	Baltimo Date	-	yland 21225 ity or Town, State
Baltimore,	Page nent o ant: if ury or		1 <b>⊠</b> Burial 2 □ Cremation 3 □ F • 4 □ Donation 5 □ Other (Specify)	Removal from State	cemetery, cremos	natory or other placess Cemete	ry 12/1	3/2004	Baltimor	ce, Maryland
Ball	permit. Pag Department Importent: i any injury o		21. Signature of Funeral Service Licens	amuseul		Name and Address Name and Address				vice, P.A. Maryland 21225
	Physician		23a. Party Enter the disease, or compleshook, or heart failure. List only of timmediate Cause (Final	ne cause on each line.	leath. Do not ent		f	or respiratory an	rest,	Approximate Interval Between Onset and Death
7	/Medical Examiner	•	disease or condition resulting in death)	Due to (or as a con		-5 07	torso		-	
	led	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	sequence of):					
, 0	ificate be executed g physician end as the burial-transit	Exar	that initiated events resulting in death) Last	Due to (or as a con-	sequence of):					
68760,	cate be	edicai		d						
.O. Box 6	death certif e attending od for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time 9 □ Unknown	etal death 3	Ectopic pregnancy Other (specify)	′		23d. Date Mont	
Δ.	w requires that the sbeen signed by the should be detache	d by Ph	Part II. Other significant conditions co	ntributing to death but not	resulting in the u	nderlying cause giv	en in Part I.	1		oute to the cause of death?
of Vital Records,	sician: The law req ; certificate has beer irector, page 2 shou	Completed by						24a. Was a autop perfor	sy pri rmed? de	ere autopsy findings available or to completion of cause of ath?  Yes 2 \sum No
ita	stan: artifica ctor, p	Bec	25. Was case referred to medical examiner?					ith (Check only or	ne)	
) \ \	Physician: r this certific ral director,	은	1X Yes 2 No		2 K ER/Outpatien		er: 4 Nursing H			
ou c	<b>9</b>	tion;	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year	28b. Time of Injury	Wor	yat k? Yes 2.M∑No		ow injury occurred	
Division	Attending r death.	Certification;	3 Suicide 6 Could not be	28e. Place of Injury - A	At home, farm, str			28f. Location (S	Street and Number	or Rural Route Number,
Ö	s after al Dire	Certi	4 Homicide determined	building, etc. (Sp At corre		ouse		Jessup	m. D Rou	te 175
	To the Hospitel or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical (		sician: To the best of my ner: On the basis of exam and manner stated.						
	To the within To the comp	Me	29b. Signature and title of certifier	u D		29c. Licens				Month, Day, Year) 2004
	9		30. Name and address of person who co	ompleted cause of death (	(Item 23a) (Type,	Print 111 Per	nn Street	, Baltin	nore, MD	21201
	Sta Registi		31. Date fited (Month, Day, Year) DEC 1 0 2	32. Regi¢rrar's S	ignature 🌶	Spar				
	riegisti		בי בי בי	7		1	_			

			For Amend Ite	em 1&Unpend	Marylar Item 2	id/Depa 3a,2/,	ytment of 28a-1 pe tificate o	Health er me of Death	G840 <sup>Mg</sup>	antal bly	giene tas Reg. No?	001.	20101
			Decedent's Name (First, Min							2 Date of De	ath £	U U II	3. Time of Death
	Physici /Medic		Sandi Yvonne	Gallahan						DECEMB	ER 4,	2004	6:47 P M
	Examin		4a. Facility Name (If not institu GOOD SAMARIT		ber)		4b. City, Town	n, or Location			4c. Co	ounty of Death	
3	Funeral Director		5. Social Security Number 231-92-9927	6. Sex 1 □ M 2 1 F	. Age (In yrs.	last birthday) 47 Yrs.	If Under 1 Ye Months Day		Min.	8. Date of Bird (Month, Da Oct 2,	y, Year)	Cou	place (State or Foreign ntry) jinia
<i></i>	pu .		Usual Residence of Decedent 10a. State 10b. Cou	ntv	10c Cit	v. Town or La	cation						10d. Inside City Limits
	Aaryla f sho	ō	MD N/A	,		Ltimore							1)(Yes 2 □ No
	28a-	Director	10e. Street and Number		Bus	CIMOIC	10f. Zip Code	9		T	10g. Citize	on of What Cou	ntry?
	death with the Maryland ms 23a or 28a-f show finded by modified at	ai D	4205 Kenwood	Avenue			21206				Unite	ed Stat	es
36	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show termetic event, the Medical Examinar must be rediffed at	by Funerai	11. Marital Status  1 Never Married 2 N 3 Widowed 4 Divorce	If Yes Give	es? No		Was Decedent of Yes, specify C	uban, Mexica	an, Puerto R	cify Yes or No lican, etc.)		Race - Ameri Black, White pecify: White	etc.
9	2 hou		15. Dece	dent's Education		16a. Dece	dent's Usual Occ	cupation		_	16b. Kind	d of Business/li	ndustry
Maryland 21215-0036	be filed within 72 hours after tal Hygiene. d other than "natural", or Ite	Completed	(Specify only hig Elementary/Secondary (0-1)	nhest grade completed)  2) College (1-4	for 5+)	Cashi	kind of work doi DO NOT use ret er	ne auring mo tired)	ist of workin	9	Groce	ery	
pu	al Hyg	Be C	17. Father's Name (First, Midd							(First, Middle,	Maiden St	umame)	
yla	should to	၉	Leon W. Mille			-1		Pegg	-	ister			
Mar	d 2 sh th and 7 Is rr traum	1 3	19a. Informant's Name/Relation  Mr. Leon W. M		-		ng Address <i>(Stre</i> Keswick						o Code)
	f Heal		20a. Method of Disposition	·	20b. I	Place of Dispo	sition (Name of natory or other p		Da	ate		ation - City or T	own, State
E C	Pages nent of I int: If It		1 ☐ Burial 2 Cremation 4 ☐ Donation 5 ☐ Other	on 3 □Removal from Si r <i>(Specify)</i>	tate		ke Crema	· 1		ec 8	Belts	sville,	MD
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marke any injury or other traumatic.		21. Signature of Funeral Serv	ige Licensee	poon		Name and Ad rematic 3717 Gre					ives Ltimore	, MD
	×		23a. Part1. Enter the disease shock, or heart failure.	or complications that cal List only one cause on ea	used the deat ch line.	th. Do not ent	er the mode of o	dying, such a	s cardiac or	respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	0.		oxicat	ion						Onset and Death
	/Medical Examiner		resulting in deality	Due to (o	ras a consec	quence of):							
	sit s	iner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	b. Due to (o	r as a cons	uence of :							
Ć.	s be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (o	r as a consec	quence of):							
8760,	cate be executed physician and the burial-transit	dicai		d									
P.O. Box 6	ne death certific the attending p thed for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ res 2 □ No	I LIVE DIT	th 2□Feta nt at time of c	al death 3	Ectopic pregna Other (specify)				236	d. Date of deliv Month	ery Day Year
ds, P.	uires that the signed by d be detact	d by Ph	Part II. Other significant cond	ditions contributing to dea	ath but not res	sulting in the u	nderlying cause	given in Part	l.	23e. Did to	1		the cause of death?
Vital Records,	e faw requir has been si je 2 should l	Completed								24a. Was autop		24b. Were auto	opsy findings available ompletion of cause of
al F	yaician: The lis certificate ha									1 Yes	2 No	1 Yes	2 No
Z.	aiciar certif	o Be	25. Was case referred to med examiner? 1 ☑ Yes 2 ☐ No	Hospital:	patient 2	XER/Outpatier	nt 3□ DOA	Other		(Check only o		⊒Other (Speci	4.1
Division of	ding Phys th. : After this funeral di	ition: To	27. Manner of Death 1 Natural 5 Per	28a. Date of	Injury , Day Year)	Found 5:48	28c. lr	njury at Work? □ Yes 25	2	8d. Describe f			unk
Divisi	for Atten after dea Director	Certification:		uld not be ermined 28e. Place of building		ome, farm, str fy)	eet, factory, office		2	8f. Location (S City or Tov Saltimo	Street and I vn. State 4 re. M	205 Ker	al Route Number.
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier 1 Certi (Check only one) 1 Medi	fying Physician: To the bacal Examiner: On the basand manner	pest of my kno	owledge, deat	n occurred at the vestigation, in m	e time, date a ny opinion, de	and place, a	nd due to the	cause(s) ar	nd manner as s	stated. o the cause(s)
	To the within To the	Me	29b. Signature and title of cer		2.11	un		ense number ) C M E				signed (Month, IBER 5,	
			30. Name and address of personal MANUA MANUA	son who completed cause		m 23a) (Type,	Print) 111	PENN S	STREET	BALT	IMORE	, MARYI	AND, 21201
	Sta Regist		31. Date filed (Month, Day, You			ature							

		1 - For State Registrar	State of Maryland / I	Department of H  Certificate of I			iene 2004	39122
		Decedent's Name (First, Middle, Last)				2. Date of Deat	h	3. Time of Death
Physic		DAVID WELL	HILTON	1 1		Month / 2	08 2004	04:02 AM
/Med Exam		4a. Facility Name (If not institution, give si			Location of Death		4c. County of Death	
		UNIVERSITY OF MAR	YLAND MEDICAL S	1100	TIMORE		BALTINORS	
Funera Directo		217-07 7777	M 2□F 7. Age (In yes, last bi	rthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day,	Year) 9. Birth Cou.	place (State or Foreign ntry)
pur 🔏		Usual Residence of Decedent  10a. State 10b. County	10c. City, Tow	n or Location			· .	10d. Inside City Limits
death with the Maryland ms 23a or 28e-f show	ctor	MD BALT		DUNDA	LK			1   Yes 2   No
with the a or 28 be not	Director	10e. Street and Number 8100 Cayne	? DR	10f. Zip Code	1222	1	og. Citizen of What Cou	
ms 23	Funeral	71.0	2. Was Decedent Ever in U.S.	13. Was Decedent of H		pecify Yes or No-	14. Race - Ameri	can Indian,
4 within 72 hours after death w jiene. jiene. r than "natural", or items 23a the Modical Examinal must	by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No	Specify:	o rican, etc.)	Black, White,	NITE
2 hours		15. Decedent's Educ	ation 16a	Decedent's Usual Occup     (Give kind of work done)	ation	king	16b. Kind of Business/In	
within 7 ene. than "n	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired	1)		Self.	
td be filed ental Hygic ked other ic event, III	Be	17. Father's Name (First, Middle, Last)  DAULD. N. H.				ne (First, Middle, I	Maiden Sumame) Reishtor	)
2 shout and Me is mari	5	19a. Informant's Name/Relationship (Typ	e, Print) 19	b. Mailing Address (Street	and Number or Ru	ral Route Number	, City or Town, State, Zij	Code)
1 and Health Iem 27		20a. Method of Disposition	20b. Place	100 Coylo		Date	20c. Location - City or To	
Pages nent of int: If it		1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	moval from State	ery, crematory or other place	ory Isli	poloy	BALto. 1	
permit. Pa Departmen important: any injury	Ŕ	21. Signal to of Fune all Service License	Stella	22. Name and Addre	ss of Facility S "ILER RD.	TellA F Bolto.	MO 21234	re CHTD.
-50		23a. Rart1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused the death. Do	not enter the mode of dyin	ig, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
Physician /Medica		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence		NORUM	E		ZDAYS
Examine		Sequentially list conditions, b	HEPATIT	IS C V	IRUS			
ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	(ot):				
cate be executed ohysician and the burial-transit		that initiated events resulting in death) Last	Due to (or as a consequence	• of):				
tificate ng phys as the	Aedicai	Lis service					1	
The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown	h 3 Ectopic pregnancy 5 Other (specify)	/		23d. Date of deliv Month	ery Day Year
res that the signed by to be detact		Part II. Other significant conditions con	tributing to death but not resulting	in the underlying cause giv	en in Part I.	23e. Did tol	bacco use contribute to t	he cause of death?
w requires been sign should be	ed by	HIV/4105				1 🗆 Y	es 2 No 3 Prol	bably 4 Unknown
law reas ber	Completed					24a. Was a autops	y prior to co	opsy findings available ompletion of cause of
	Con					perform 1 ☐ Yes	ned? death? 2√2 No 1 ☐ Yes	2 No
Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:	lutration 3 DOA Oth	00	th (Check only on		6.1
Phys or this sral dis	n: To	27. Manner of Death	28a. Date of Injury 28b.	Time of 28c. Injur	4 Lituraling in		ence 6 Other (Special ow injury occurred	(y)
or Attending Physicien: The law requires t afler death. Director: Afler this certificate has been signe i in by the funeral director, page 2 should be	atior	1 Natural 5 Pending investigation	(Month, Day Year)		k? Yes 2 □No			
To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office		28f. Location (Si City or Town	treet and Number or Run n, State)	al Route Number,
e Hospitel or At n 24 hours after o te Funerel Directionally filled in by	edical (		ician: To the best of my knowledger: On the basis of examination a and manner stated.					
To the Hos within 24 ho To the Fun completely	Me	29b. Signature and title of certifier		29c. Licens		1	9d. Date signed (Month,	
(		In Charles	On C	03	8683		12.09.	2004
įΧ		30. Name and address of person who co	mpleted cause of death (Item 23a)	(Type, Print) SREENE	57 31	ATINO	RE NO	2/20/
5	State	31. Date filed (Month, Day, Year)	32. Registrar's Signature	1 .				
Regis	strar	DEC 1 0 2004	128.000	MOOKA!				

Amend item#19a, perint; G838, 12/28/04 Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [ ] [ ] 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month SHAVON **Physician** HENR DECEMBER OS 2000 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner SAMARI BALTIMORE HOSPITAL 4001 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1□ M 3€F Director SHLINGWA Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c, City. Town or Location 10a. State 10b. County in than "natural", or Itame 23a or 28a-f show the Medical Examinar must be notified at 14 Yes 2 □ No Bestimores by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21245 AVE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Yoo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: Specify: Buck 3 ☐ Widowed 4 ☐ Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "na sny injury or other treumatic event, the Medic once. Elementary/Secondary (0-12) College (1-4or 5+) MNY NONE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MAULINE ဥ HENLY mant's Name/Relationship (Type, Print)
Pauline Linda Henry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LUZEFNE 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place, Burial 2 ☐ Cremation 3 ☐ Removal from State + ZION CEMERE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Muci à 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ANOXIC /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed for use as the burial-transit signed by the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ◯ No 24e Was an autopsy performed? page 2 certificate has or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medicai Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 100 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Atter Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 
Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Momicide To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0058913 MD DECEMBER OS 2004 Manisha LOUIRAVEN BOULEVARS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOOD SAMARITAN BAHL MANISHA MARYI HOSPITAL 31. Date filed (Month Pay Year) 0 32. Registrar's Signature State 2004

Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. N2 () () (4)

			For Stata Registrar	tate of Ma	Cer	artment of H	Death	F	nag. N2004	39124
П	Physicia	an	<ol> <li>Decedent's Name (First, Middle, Last)</li> <li>Lucille Jane F</li> </ol>	lawkins				2. Date of Dea Month Decembe	Day Year	3. Time of Death  8:35 P M
	/Medic Examin	al	4a. Facility Name (If not institution, give stre			4b. Cily, Town, or	r Location of Death	Decembe	4c. County of Dea	
	CAdmin	61	Holly Hill Manor			Towso	חו		Baltimor	е
	Funeral		5. Social Security Number 6. Sex	2 💢 F	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day June 18	year) 9. Bir	thplace (State or Foreign ountry)
	Director		489-07-2861 Usual Residence of Decedent	24	87 Yrs.			June 18	3, 1917 Mis	ssóuri
	/land		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Man e-f sh	ţċ	Maryland Baltimore		Parkt	on				1 ☐ Yes 2 💢 No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	
	ath w 123a		1135 Dairy Road			2112				S.A
	items	Funerai	11. Marital Status  1 Never Married 2 Married	Was Decedent Armed Forces?	Ever in U.S. 13. V	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spec an, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
336	i 72 hours after death with the Maryland "neturel", or Items 23a or 28e-f show idical Examinational be collined at	by	3 Widowed 4 Divorced	1 ☐ Yes 2 XX N If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify:	lhite
9-0	hin 72 hou an "netura Medical E	Completed	15. Decedent's Educat (Specify only highest grade c	ion ompleted)	16a. Deced	dent's Usual Occup	ation during most of working	na l	16b. Kind of Business	
21	in a w	nple	Elementary/Secondary (0-12)	College (1-4or 5	life.	DO NOT use retired	i)			
72	be filed wit tal Hygiene d other the		12 17. Father's Name (First, Middle, Last)			Sales	18. Mother's Name	(First, Middle,	Jewelry Maiden Sumame)	
Maryland 21215-0036	build be f Mental I arked of atic eve	To Be	Hugo Weismant	o1			Lucille	, ,	Mueller	
ary	and Menis markers markers	ř	19a. Informant's Name/Relationship (Type,		19b. Mailir	ng Address (Street			r, City or Town, State,	Zip Code)
	alth a		Linda Franklin	Daughter	water the second	the same of the sa	d. Parkto	n, Md.	21120	
ore	ges 1 au it of Hea if item or othe		20a. Method of Disposition  1 □ Burial 2 M Cremation 3 □ Rem	oval from State	20b. Place of Dispo cemetery, crer	sition (Name of matory or other place	Di	ate	20c. Location - City or	
Ë	nit. Pages artment of ourtent: If it injury or o		1 ☐ Burial 2 【X Cremation 3 ☐ Rem `4 ☐ Donation 5 ☐ Other (Specify)	1 -7			orp. 12-8-		Towson	Maryland
Baltimore,	permit. Pages Department of I Importent: if its any injury or o		21. Signature of Funeral Service Ligensee		22	Ruck To 1050 Yo	ss of Facility Dwson Fune: Ork Rd. Tol	ral Hom Json. M	e, Inc. d. 21204	
			23a. Part1. Enter the disease, of complications shock, or heart failure. List only one	ions that caused	the death. Do not ent					Approximate Interval Between
4	Pnysician	114	Immediate Cause (Final disease or condition	acut	e renal	failu	re			Onset and Death 4 days
	/Medical Examiner		resulting in death)		a consequence of):					Edans
		<u></u>	Sequentially list conditions, b.		a consequence of:					5 augs
	uted d ansit	Examiner	Sequentially list conditions, and leading cause. Enter Underlying Cause (Disease or injury that initiated events c.	Demi	entia					5 days
ó	an andrial-tra		resulting in death) Last	Due to (or as	a consequence of):					0
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and cage 2 should be detached to use as the burial-transit	edical	d.							
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Box	leath cert attending I for use a	Physician/M	in the past 12 months?		2 Fetal death 3	Ectopic pregnancy Other (specify)	1		23d. Date of de Month	Day Year
P.O.	that the de led by the detached	ysi	1  Yes 2  No 9  Unknown	9□ Unknown						
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Vital Records,	w require been sig should b	ted t	Atheroscierot	ic co	ardio-va	scular	disease	1 T	′es 2 No 3 □ P	robably 4 Dunknown
ecc	elawr has be je 2 sh	Completed	Glaucoma					24a. Was autop	sy prior to	utopsy findings available completion of cause of
<u>=</u>	: The l							1 Yes	rmed? death? 2 No 1 Yes	s 2 No
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of		H	1 Yes 2 No 27. Manner of Death	28a. Date of Inju (Month, Da	ent 2 ER/Outpatier	f 28c. Injur	vat 2		lence 6 Other (Spenow injury occurred	эспу)
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Division	l or Attendi after death Director: A	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inj building, et	ury - At home, farm, str c. (Specify)	reet, factory, office	2	28f. Location (S City or Tow	Street and Number or R m, State)	ural Route Number,
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	To the within To the	Me	29b. Signature and title of certifier			29c. Licens	se number	:	29d. Date signed (Mon	
	8		Than You	Deltn	ear A D.	D 57	454		12/07/0	4
1	18		30. Name and address of person who com	pleted cause of c	leath (Item 23a) (Type,	Print)			-1	
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how		10a. State	10b. County			1		Town or Lo	cation			- OC		20,	1,72		10d. Inside C	
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Amend item 4a per 28 838 12-10-04 yt

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	Physici	an	Decedent's Name (First, Midd						2. Date of Deat Month		Year	3. Time of Death
	/Medic		Joan	Agnes		На	rtwell		Novembe		2004	10:23 a <sup>M</sup>
e de la company	Examin	er	4a. Facility Name (If not institution  Country Home	Solomons I			Harwoo			Anne	y of Death Arund	
ľ	Funeral Director		5. Social Security Number 199–24–1343	6. Sex 7. Ag 1 ☐ M 2 🗶 F	e (In yrs. last 72	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 2,	Year) 1932	Coun	lace (State or Foreign try) sylvania
	land ow		Usual Residence of Decedent  10a. State 10b. Count	y	10c. City, To	own or Lo	cation				1	0d. Inside City Limits
	Mary P-f sh	tor	MD Anne	Arunde1	Han	cwood	L					1 ☐ Yes 2 No
	th the	Director	10e. Street and Number		-		10f. Zip Code	***************************************	1	0g. Citizen of	What Cour	itry?
	23£ ust b		4187 Solomons	Island Road			207			US		
21215-0036	72 hours after death with the Maryland neturel', or Items 23s or 28e-f show Itsal Examiret must be mailfied at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Ma 3 □ Widowed 4 ★ Divorce	If Vac Cinco			Was Decedent of Hi fYes, specify Cuba 1□Yes 2X No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ice - Americ ack, White, ify: Wh	
5-0	be filed within 72 ho ital Hygiene. id other then "netur event, the Neutoel	Completed		nt's Education est grade completed)	10	(Give	dent's Usual Occupa	during most of work	ing	16b. Kind of E	Business/Ind	dustry
121	within iene. • then "	mpl	Elementary/Secondary (0-12)	College (1-4or 5		life. L Capta	DO NOT use retired	)		USPH	ıc	
	a filed v other t	e Co	17. Father's Name (First, Middle	<u> </u>		Japta	111	18. Mother's Nam	e (First, Middle, M			
lan		o B	Wayne F.	Hartwell				Agnes K	eifer			
Maryland	s t and 2 should f Health and Men item 27 is marke other treumetic	-	19a. Informant's Name/Relation	ship (Type, Print)	1	9b. Mailin	ng Address (Street a	and Number or Rur	al Route Number,	City or Town	, State, Zip	Code)
	1 and 2 Health tem 27 i		Jim Burr (F	riend)			Melvin Av					_
Baltimore,	00		20a. Method of Disposition				sition (Name of natory or other place Nat. Cen			20c. Location	,	
ıltin	permit. Pag Department Importent: I eny injury o		* 4 ☐ Donation 5 ☐ Other (		HITTI	22	. Name and Addres	s of Facility	_	rlingt	.OII , V.	A
B	permit. Departr Importe eny inji		> Salar	1 /1/1			Hardesty 12 Ridge	Funeral	Home, P.	A. lis. M	D 214	01
	101		23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that caused tonly one cause on each li	the death. D							Approximate Interval Between
Š	Physician		Immediate Cause (Final disease or condition	_a P	eine	2 dia						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence	ce of):						
L		e	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as	a consequent	ce of):						
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	1								
o,	an an	Exa	resulting in death) Last	Due to (or as	a consequent	ce of):						
68760,	ficate be executed physician and s the burial-transit	edical		d								
			IF FEMALE:	230 If was autooma	of programme							
Вох	death certifi e attending id for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal dea		Ectopic pregnancy Other (specify)				ate of delive onth	ry Day Year
P.O.	0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	time or death	, ,,	Other (specify)					
	The taw requires that the te has been signed by the bage 2 should be detache	by Pt	Part II. Other significant condit	tions contributing to death b	ut not resultin	g in the ur	nderlying cause give	n in Part I.	23e. Did tob	acco use con	tribute to th	e cause of death?
rds	w require been sig should b								1 ☐ Ye	s 2⊟No	3 🗌 Prob	abiy 4 Dunknown
of Vital Records,	taw re as bei 2 sho	ompleted							24a. Was ar		Were autop	osy findings available inpletion of cause of
= E		Соп							perform 1 Yes 2	red?	death? 1 🔲 Yes	
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medic examiner?	Hospital			Otho	26. Place of Deat				
of	Phys	- To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatie	nt 2 EP/	Outpatien  b. Time of	t 3 DOA	ar: 4 ☐ Nursing Ho	me 5 Reside			)
on	th. : After s funer	itlon	1 ☑Natural 5 ☐ Pend		y Year)	injury	Work	r? res 2 □ No		,2., 0000		
Division	or Attending after death. Director: After d in by the fune	ertification:	3 ☐ Suicide 6 ☐ Could	1 not be mined 28e. Place of Inj building, et		, farm, stre	eet, factory, office		28f. Location (Str City or Town		ber or Rura	Route Number,
Ō	itel or A rs after el Dire	Cert		Dunding, et	c. (openy)				Sity of Town	, J.W.O/		
	To the Hospitel or a within 24 hours after To the Funerel Direct completely filled in E	edical	29a. Certifier 1 ☐ Certify (Check only one)	ing Physician: To the best if Examiner: On the basis of and manner sta	f examination	dge, death and/or inv	n occurred at the time restigation, in my op	e, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and mate and place,	anner as sta	ated. the cause(s)
	Fo the within Fo the	Med	29b. Signature and title of certifi		7 -	<u> </u>	29c. License	number	29	d. Date signe	ed (Month, L	Day, Year)
	1		Pot 1	le Freel	la	7	0-	28 37	3	12-1	-04	
	100		30. Name and address of person	n who completed cause of d	eath (Item 23	a) (Type,	Print)			14 1		
			13 9 XL 31. Date filed (Month, Day, Yea DEC 1	Dolomen 5	ar's Signature	K.		Anney.	olis	v x	71	4 4/
	Sta Registr	_	31. Date filed (Month, Day, Year DEC 1	0 2004	w B	190	and I					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 39127 State Registrar AMEND ITEM #26 PER VERB Con 1888 at 20 10 10 10 11 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician 6:05 A M 29, 2004 November Ann Marie Hawkins /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cheverly
If Under 1 Year | If Under 24 Hrs. Prince George Gladys Spellman Nursing Center 7. Ağe (İn yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours 1 □ M 2 🕱 F 76 195-20-9581 Yrs June 18. 1928 Pennsylvania Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Cheverly Director Prince George 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Items 23a 2900 Mercy Lane 20785 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filled within 72 hours atter c Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Exemples 2008. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify Specify: Completed by White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Security College (1-4or 5+) Administrator 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Regina Sheehan Joseph Gannon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sherin Hawkins/Daughter 2122 Brown Rd. Finksburg, MD 21048 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 12/28/04 Arlington National Arlington, VA 4 Donation 5 Other (Specify) 21. Sharture of Property Service Licensee 22. Name and Address of Facility Murphy Funeral Home 4510 Wilson Blvd. Arlington, VA 60 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition **Physician** 1 day Sepsis resulting in death) /Medical Due to (or as a consequence of): **Examiner** Respiratory Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) ed by the attending physicien detached for use as the buria Physician/Medical IF FEMALE: . If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown 1 signed by the Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown peed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Urinary tract infection has autopsy performed? Multi Infarction Dementia this certificate 1 Yes 2√ No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 rsing Home 5 Residence 6 Other (Specify) 1 Yes 2√ No 2 ER/Outpatient 3 DOA Certification: To 1 Papatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation the \* Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide after within 24 hours a To the Funeral I pellij 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 94 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 11/29/04 D16273 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Revathy Murthy 6130 Landover Rd. Cheverly, MD 20785

State Registrar 31. Date DE COMP. 04. 2004

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records,

32. Registrar's Signature

			1 - For State Registrar	State of M	1arylar		artmen <i>rtificat</i>			and M		giene		4	391	28
	Physic		Decedent's Name (First, Middle, La:     Mary	Opal		Н	lerre1	1		1	2. Date of Dea Month Decembe	Day		ear 04	3. Time o	
	/Medi Examir		4a. Facility Name (If not institution, give	street and number	7)		4b. City,	Town, or	Location of		2000		County of		7.00	<i>5</i> a
			1151 Severnview	Drive					ville	-			Anne	Aru	nde1	
	Funeral Director		213 30 7077	ex 7. A	ge (In yrs. 88	. last birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	Min.	8. Date of Birth (Month, Day Sept. 2	2 , 19	16 g	Birthp Coun Γenr	lace (State htry) Nessee	or Foreign
	land		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ity, Town or Lo	ocation							1	0d. Inside C	City Limits
	Mary Fied	į	MD Anne A	runde1		Crowns	ville								1 🗌 Yes	2 X No
	or 288	Director	10e. Street and Number				10f. Zip	Code			1	10g. Citiz	en of Wha	at Coun	itry?	
	ath wi	rai	1151 Severnview	Drive				2103	2				USA			
	er dez	Funerai	11. Marital Status	12. Was Deceden Armed Forces	?	J.S. 13.	Was Deced If Yes, spec	lent of Hi	spanic Orig n, Mexican	gin? (Spec , Puerto P	cify Yes or No- Rican, etc.)	1	4. Race Black, \			
36	I', or	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🔀 If Yes, Give Year or Dates:			1 ☐ Yes	2X No	Specify:				Specify:	Wh	ite	
5-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-1 show disal Examinat must be rodified at	ted	15. Decedent's Ed	lucation		16a. Dece	dent's Usua	I Occupa	ition			16b. Kin	nd of Busin	ness/Inc	dustry	
2121	within 7 iene. 'than "n	Completed	(Specify only highest gra	College (1-4or	5+)		kind of wor DO NOT us		uring most	t of workin	19					
121	led w lygier her th		AZ Cabada Nasa (Cian Addula Cas)			Home	emaker	:					n Hon	ıe		
Maryland	12 should be filed within h and Mental Hygiene. 7 is marked other than "traumatic event, the Mes	Be	17. Father's Name (First, Middle, Last)  Robert Greer								(First, Middle,	Maiden S	Sumame)			
Z	should nd Me mark matic	2	19a. Informant's Name/Relationship (	Type, Print)		19b. Maili	na Address	(Street a			Spears Route Number	r. City or	Town, Sta	ate. Zio	Code)	
	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examinar must be routified at		Sherry G. Sulliv	an (Daugh	ter)						Crowns					
J.e.	ges 1 and 1 of Health I is it is a 27 or other tri		20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐	Dameur from Chat		Place of Dispo cemetery, crei	sition (Nan	ne of					ation - Cit			
Ë	Pages ment of I		'4 □ Donation 5 □ Other (Specific		Lal	kemont	Mem.	Gard	lens :	12/7/	′2004 I	David	dsonv	'i11	e, MD	
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Sovice Licer	and	11	22	Name and Harde 12 Ri	d Addres sty dge1	s of Facility Funer y Ave	al Henue,	ome P.A Annapo	is,	MD	214(	01	
F			23a. Part 1. Enter the disease or com shock, or heart failure. List only	olications that cause one cause on each	d the dear										Approximat Interval Bet Onset and	tween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a										_	42	
п	Examiner			Due to (or as	s a consec	quence or):										
Ц,	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	s a consec	quence of):										
	and trans	Examiner	cause. Enter Underlying that initiated events resulting in death) Last	c												
8760,	be executed sician and buriat-transit	al E	iosaning in dodiny East	Due to (or as	s a consec	quence of):										
289	physical phy	dical		d												
XO.	eath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			-					23	3d. Date of	f delive	rv	
<u> </u>	death te atte	Physician/Med	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a			]Ectopic pre ] Other (spe						Month		-	Year
P.O	at the de d by the etached	Phys	9 Unknown	9∐ Unknown												
Vital Records,	The law requires that the death certificate be executed to has been signed by the attending physician and otge 2 should be detached for use as the burial-transit	by	Part II. Other significant conditions c	ontributing to death	but not res	sulting in the u	nderlying ca	luse give	n in Part I.						ecause of dably 4 1211	_
CO	w requires been si should I	Completed						, ,			24a. Was a	n	24b. Wer	e autor	sy findings	available
Re	The lay ate has page 2	omp	-								autops perforr	ned?	prior deat 1 🔲	r to com th?	npletion of c	ause of
ita		Be C	25. Was case referred to medical examiner?						26. Place	of Death	1 ☐ Yes 2 (Check only on	9)		195	2 140	
of V	d S	To	1 Yes 2 No			ER/Outpatier		Mary Mary	4   1401	rsing Hom	e 5. Aeside	ence 6	□Other (	Specify	)	
	ing After une	ion:	27. Manner of Death  1. ■ Natural 5 ■ Pending	28a. Date of Inj (Month, Da	ury ay Year)	28b. Time of Injury		Bc. Injury Work			8d. Describe ho	w Injury	occurred			
Division	tor: the	ertification;	2 Accident investigation 3 Suicide 6 Could not be		itury - At h	ome farm str	M factory	-	es 2□N		Bf. Location (St	reet and	Numbero	r Qural	Pouta Num	ahor
Οį		Certii	4 Homicide determined	building, e	tc. (Specil	fy)	eet, ractory	, 011100		20	City or Town		14dinber 0	riorai	Houle Wall	Der,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edicai (	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the best liner: On the basis of and manner s	of examina	owledge, death	n occurred a vestigation,	at the time in my op	e, date and inion, deat	place, ar h occurred	nd due to the ca d at the time, da	ause(s) a ate and p	nd manne place, and	r as sta due to	ited. the cause(s	;)
	To the To the Complet	Me	29b. Signature and title of certifier					License			2		signed (M			
)	6		19U1-11	Ulli-			1	13.	074	8		12	-0	6-0	4	
	(m)		30. Name and address of person who	completed cause of	death (Iter	n 23a) (Type,	Print) Luu	gral	(5	MT,	> 2/40	. /				
	Sta Registr		31. Date filed (MDEC), 1°0 20	32 Regist	rar's Signa	Key A	out.	-								

Physici /Medic	an	1. Decedent's Name (First, Middle, Las	•				2. Date of De	Day	2004	3. Time of Dea
		JASON HARDWIC					Decembe			15:31
Examin	ier	4a. Facility Name (If not institution, give 1345 East Patapsc.	o Street			timore		4c. County	y of Death	
Funeral Director		213-17-2020	7. Age (In yrs. It M 2□F 31	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours N	frs. 8. Date of Bird lin. 3/26/1	у, <sub>Үөаг)</sub> 973	9. Birthpl Count MARY	ace (State or Fo try) LAND
Mo TI		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation				10	od. Inside City Li
a or 28a-f show	ţ	MD		BALT	IMORE					1 <b>X</b> Yes 2 □
or 28a-f	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Count	try?
238 0		1345 E. PATAPSC	O AVENUE		2122	2.5		USA		
or Items coloer m	by Funeral	11. Marital Status  1 XXever Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.s Armed Forces? 1 ☐ Yes 2 ☒️☒o If Yes, Give Year or Dates:	11	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2∰No	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or No Jerto Rican, etc.)		ce - America ck, White, e	
		15. Decedent's Ed		16a. Decec	ient's Usual Occupa	ation		16b. Kind of B	usiness/Ind	ustry
than	Completed	(Specify only highest grades) Elementary/Secondary (0-12)	de completed)  College (1-4or 5+)	(Give life. L	kind of work done of DO NOT use retired CHANIC	turing most of	working	SERVI (		
ntal Hygiene od othar tha avant. Itel		17. Father's Name (First, Middle, Last)		1111	OHHIVE	18. Mother's I	Name (First, Middle,			ATTON
and Mental Hygi is marked othar aumatic avant. I	To Be	ROBERT JAMES HAI	RDWICK				DRA J.			
i Health and Men tam 27 is marke other traumatic	-	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailin	ng Address (Street a	and Number or	Rural Route Numbe	or, City or Town,	State, Zip	Code)
alth a		SANDRA J. WEAVE	R - MOTHER	RT 1	BOX 91 D	, INDE	PENDENCE,	WV 263	75	
nent of Health nt: If itam 27 i ry or other tra		20a. Method of Disposition  1 Burial 2XX remation 3   4 Donation 5 Other (Specify	Removal from State	emetery, cren	sition (Name of natory or other plac CREMATORY	'	Date 2/9/2004	20c. Location	•	
Department of I Important: If its any injury or of		21. Signature on Funeral Service Usen KELLY CREGORY	548 D	22	. Name and Addres	s of Facility	FINK FUNE Y S., GLE	RAL HOM	E, PA	
physician and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.  Due to (or as a consequ  c.  Due to (or as a consequ  d	uence of):						
	0		23c. If yes, outcome of pregnal						te of deliver	y Day Year
by the attending physiached for use as the	hysician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown		Ectopic pregnancy Other (specify)					
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		1 - For State Registrar			Cei	tificate of L	Death		Reg. No. U U	•	39130
Physic	ian	1. Decedent's Name (First, Middle, L	-					2. Date of Dea	, Day Y	ear	3. Time of Death
/Med	ical	4a. Facility Name (If not institution, g	Beulah		ns	4b. City, Town, or	Location of Deat	Decemi	4c. County of	Death	7,001
Exam	ner	Mercy Hospital			ospice	Baltim			N/A		
Funera	П	Social Security Number 6.	Sex 1 □ M 2X □ F	7. Age (In yrs.	. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		h y, Year)	Birthplac	e (State or Foreign
Directo	3	236 32 4471 Usual Residence of Decedent		78	Yrs.			March 5	, 1926 V	vest ]	Virginia
/land		10a. State 10b. County		10c. C	ity, Town or Lo	cation				10d.	. Inside City Limits
a⊷feh	ctor	Maryland N/A		В	altimor	:e					1 <b>½</b> Yes 2 □ No
death with the Maryland ms 23e or 28e-f ehow E: sist be mutilised at	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of Wh	at Country	?
sath w	rai	3805 - 8th Str		adont Everin I	10 12 1	2122		Specify Vos or No	U.S.	American	Indian
iter de	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed F			Was Decedent of Hi f Yes, specify Cuba	in, Mexican, Puer	to Rican, etc.)		White, etc.	
036 036 0036 001, 01	þ	3 X Widowed 4 ☐ Divorced	If Yes, G Year or I	2 ∰ No ive Dates:		1 ☐ Yes 21X No	Specify:		Specify:	White	е
# E// S 215-0036 tthin 72 hours at lie. I waterel; or I wa	Completed	15. Decedent's (Specify only highest of	Education trade completed,	)	(Give	lent's Usual Occup kind of work done	during most of wo	rking	16b. Kind of Busin	ness/Indus	itry
within soe.	Idm	Elementary/Secondary (0-12)	Coltege	(1-4or 5+)	Cle	DO NOT use retired : <b>rk</b>	1)		Carr-Lo	owery	Glass
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lan lid be fental riceve	To Be	Olzie	Farley				Ke:	rmith Wh	ite		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel; or items 23s or 28s-1 ehow eny injury or other traumatic event, the Medical Examination and the middled at		19a. Informant's Name/Relationship Peggy Smith /		er		ng Address (Street a - 8th Sti			er, City or Town, St e, Maryla		
or Fe, stan item item		20a. Method of Disposition		20b.	Place of Dispo cemetery, crer	sition (Name of natory or other place	:е)	Date	20c. Location - Ci	ty or Town	i, State
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Salt ermit. lepartu mport my inj		21. Signature of Funeral Service Lic	ensee		/	2. Name and Addres	G		eral Ser		
2030		23a Part Enter the disease or co	molications that	caused the dea	th. Do not ent	001 Ritch	ie Highw	ray Bal	timore,		and 21225
		23a. Part. Enter the disease, or control of the con	ly one cause on	each tine.	1 0-					ln'	nterval Between Inset and Death
Pnysicia /Medica		disease or condition resulting in death)	a Due to	o (or as a conse	quence of):	carie					
Examine		Convention to the ties and distance	b								
<b>E</b>	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	(or as a conse	quence of):						
760, te be executed ysician and	Examiner	that initiated events resulting in death) Last	c. Due to	o (or as a conse	quence ot):						
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Division of Vital Records, P.O. Box 68760, afor the death certificate be executed after death. Box filter death certificate be executed bisector. After this certificate has been signed by the attending physician and it in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant		utcome of pregr		Ectopic pregnancy	,		23d. Date of	-	ay Year
O. E e deal inhe att	sicia	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4∏Preg 9∏Unki	gnant at time of nown		Other (specify)			Monti	Da	ty feat
P.C. hat the	Phy	Part II. Other significent conditions	s contributing to	death but not re	sulting in the u	nderlying cause give	en in Part I.	23e. Did to	obacco use contrib	ute to the c	cause of death?
ds, uires ( signe	d by		•			, ,		1 🗆 '	Yes 2□No 3	robabl	ly 4 🗆 Unknown
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Re The la te has	J Wo							autor perfo	rmed? dea	or to compl ath? Yes 2[	letion of cause ot ☐ No
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on C ling P	ion	27. Manner of Death  1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga		of Injury nth, Day Year)	28b. Time o Injury	Wor	y at k? Yes 2 □ No	28d. Describe	how injury occurred		
risic Attend death death cctor:	fical	3 Suicide 6 Could no	be 28e. Plac	ce ot tnjury - At I	home, farm, str	reet, factory, office			Street and Number	or Rural R	loute Number,
Div al or safter safter of Dire	Certification:	4 Homicide	buil	ding, etc. <i>(Spec</i>	eity)			City or Tou	vn, State)		
Division of Vital To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	ledical (								cause(s) and mann		
the H hin 24 the F	Medi	one)  29b. Signature and title of certifier		nner stated.		29c. Licens			29d. Date signed (		
T vivit	-	29b. Signature time of Continuo	/ ~			111	0000		12/6/	2009	
6		30. Name and address of person wh	o completed car	use of death (Ite	em 23a) (Tvpe	Print)	0020				
( ')		David, Rise	hera 3	DI 57	Paul	PL Ba	Himor	e md.	2120	2	
	tate	31. Date filed (Month, Day, Year)	VI	Registrar's Sign	nature						
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			4 101	partment of Health and Mertificate of Death	lental Hygi	
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physici /Medio		Onelia Herrera		December	8 2004 7:58 A.M
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deeth
			435 - 5th Avenue	Baltimore		Anne Arundel
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	/) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day,	9 Birthplace (State or Foreign
0.00	Director		213 26 2734 Sual Residence of Decedent	,	June 25,	1923 Puerto Rico
	/land		10a. State 10b. County 10c. City, Town or I	ocation		10d. Inside City Limits
	Mary	tor	Maryland Anne Arundel Baltim	ore		1 ☐ Yes 2X No
	th the	irec	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country?
	hours after death with the Maryland tural', or Iteme 23a or 28a-f ahow al Examinar must be notified at	Funeral Director	435 - 5th Avenue	21225		U.S.
	teme feme	nuel	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕱 No If Yes, Give	Yes 2 No Specify: Pue		
8	hour	ed t	15. Decedent's Education 16a Dec	edent's Usual Occupation	16	6b. Kind of Business/Industry
715	within 72 ene. than "na	Completed	(Specify only highest grade completed) (Giv	e kind of work done during most of worki DO NOT use retired)	ng	Se. Faire of Business Industry
212	d with	mo	Elementary/Secondary (0-12) College (1-4or 5+)  12th HO	memaker		Own Home
b	be filed ital Hygid of other avant, I	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Ma	aiden Sumame)
yla	should bind Ment	To	(not available) Torres	Mar	la Jusino	
Maryland 2:1215-0036	2 shc and Is my	N		ling Address (Street and Number or Rura		
	l and fealth in 27 her tr					Maryland 21225
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importants: If item 27 is marked other than "natural", or iteme 23a or 28a-f ahow any figury or other treumatic avant, in Medical Examiner must be nutified at ance.			ematory or other place)		Oc. Location - City or Town, State
Ë	ntmer rtant: njury		'4 □Donation 5 □Other (Specify) Glen Hav			len Burnie, Maryland
Ba	permit. Departr Importa any inju			22. Name and Address of Facility Gor 2001 Ritchie Highwa	nce Funer	cal Service, P.A.
A)	7 5	_				imore, Maryland 21225
	Dhusisian		23a. Part1. Enter the disease, of complications that caused the death. Do not en shock, or heart failure. List only one cause on page line.  Immediate Cause (Final			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)  Due terfor as a consequence of):	Heart ta	cure	1 Day
	Examiner		Caronary	Astery Dure	BAI	2 Years
		Jer	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	d		0.12
	cuted nd ransil	Examiner	that initiated events C.			
760,	ate be executed nysician and he burial-transit		resulting in death) Last Due to (or as a consequence of):			
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Вох	attender for us	ian	an title past 12 mprittis:	□Ectopic pregnancy		23d. Date of delivery  Month Day Year
P.O.	that the de led by the a detached t	ysic	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		
۳.	signed by	y Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?
Records,	quires n sign				1 ☐ Yes	2 1 3 Probably 4 Unknown
S	s been si	Completed			24a. Was an	24b. Were autopsy findings available
	The lay	ШО			autopsy performe	prior to completion of cause of death?
Vital		BeC	25. Was case referred to medical	26. Place of Death	Check only one)	No 1 □ Yes 2 □ No
	nysici ils ce direc	ToE	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie			ce 6 Other (Specify)
Division of	nding Physicien: th. : After this certifica s funeral director, p		27. Manner seath 28a. Date of Injury (Month, Day Year) Injury		8d. Describe how	
Sio	r Attendii er death. rector: A by the fu	catio	2 Accident investigation	M 1 Yes 2 No		
Ž	or Attendate death Director:	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	treet, factory, office	8f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
	urs a		200 Continue 4 Martin Physics T. B.			
	To the Hospitel or Attending Physicien: within 24 hours after death: To the Funerel Director: After this certific completely filled in by the funeral director.	Medicai	29a. Certifier (Check only one) 1 Gertifying Physician: To the best of my knowledge, dea (Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, a nvestigation, in my opinion, death occurre	nd due to the caused at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
	o the	Me	29b. Signature and May of certifier	29c. License number	29d	. Date signed (Month, Day, Year)
)	- s + ő		· Certifuge My Attending Doc	TH D2168 A		12-8-2004
	h	1	30. Name and address of person who completed cause of death (Item 23a) (Type	Print)		,
	Ü		CV. CYRIAC. M.D 8021 R	CTEHIR GWY	MASA	12-8-2004 DRNA, MD 21127
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature			
5.	Registr	ar	DEC 1 0 2004 Benus	1 Some de		

WINIFRED HUNT **Physician** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 1 1 - For Stete Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month HUNT WINIERED December 2004 6:30 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore 4442 Fenor Road Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 M 20 F 60 Yrs Director 565 60 1064 August 14,1944 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ehow traumetic event, the Modical Examiner must be notified at 1 ☐ Yes 2X No Baltimore Baltimore Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 21227 U.S. 4442 Fenor Road items 23e Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. ☐Yes 2XNo 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Year or Dates "naturei" Completed | 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within in and Mental Hygiene. 7 ie marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 10th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Betty May Kelly Robert A. Griffith 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an Louis Schmidt / son 2808 Louisiana Avenue Baltimore, Maryland 21227 item 27 other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State ō Department of Important: If any injury or once. Cedar Hill Cemetery 12/9/2004 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee remucan 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BRONCHOGENIC CARCINGMA **Physician** rein disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list monations if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) or Attending Physicien: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760 attending physician IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) 4☐Pregnant at time of death P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by Division of Vital Records, 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Z No Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No s after death. 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a 29a Certifier 1 🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 06982 Decaster 6, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAIN Make And 2/129 ICSEAH H Miller MA 400 CATON 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

DEC 1 0 2004

			For State Registrar	State of	Maryland	-	artment of H		nd Mental Hy	_ ^	2004	391	133
			Decedent's Name (First, Middle,	Last)					2. Date of De Month			3. Time o	f Death
	Physicia /Medic		Wilbert	F		cker			Decemb	er 5,	, 2004	9:59	РМ
,	Examin	er	4a. Facility Name (If not institution,	-	ber)		4b. City, Town, or				County of Death		
_			Holy Cross Hos		7. Age (In yrs. Ia	st birthday)	Silver S				ntgomery 9. Birth	place (State	or Foreian
	Funeral Director		579-12-5606	1⊠M 2□F	80	Yrs.	Months Days	Hours	Min. (Month, Da August 2	iy, Year) 23 <b>,</b> 19	Cou	intry) : Virg:	
	ס		Usual Residence of Decedent						1==0				
	anylar show	_	10a. State 10b. County		Tuc. City	, Town or Lo						10d. Inside C	oty Limits 2 ☑ No
	death with the Maryland ims 23a or 28a-f show rmust be notified at	Directo	Maryland Mor  10e. Street and Number	ntgomery			10f. Zip Code	lockvi	lle	10a. Citiz	zen of What Cou		
	with 3a or							2085	2			d Stat	h o o
	death	Funeral	11. Marital Status	12. Was Deced	dent Ever in U.S	3. 13.	Was Decedent of Hi		in? (Specify Yes or No Puerto Rican, etc.)	)- 1	14. Race - Amer Black, White	ican Indian,	.es
0	after or Ite		1 Never Married 2 Marrie	ed 1 X Yes	2 □ No		ires, specily cuba 1 □ Yes 2 🎇 No		Tuesto Filoari, etc.,		Specify:	, etc.	
2-002p	be filed within 72 hours after death with the Marylan tal Hygiene. d other then "neturel", or Items 23a or 28a-f show event, Ite Manical Examiner must be notified at	d by	3 X Widowed 4 ☐ Divorced  15. Decedent*	Year or Da	tes: WW I	I	dent's Usual Occupa				nd of Business/li	White	
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yland	ss 1 and 2 should be of Health and Mental item 27 is marked crother traumatic even	户		Robert M	lonroe				Thelma Be				
Mar	12 shu and r sm raum		19a. Informant's Name/Relationsh						r or Rural Route Numb				
a,	1 and Health tem 27		Samuel Worsham/ 20a. Method of Disposition	Step-son	20b. PI	ace of Disno	sition (Name of	1	re Lothian,		y Land 2 cation - City or T		
Банттог	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		1 Burial 2 Cremation 4 Donation 5 Other (Sp				natory or other place nery orium Inc.		ecember 2004	D 241	1		. 1
	nit. P vartme ortan injur		21. Signature of Funeral Service L		1 0	remato 22	P. Name and Addres	ss of Facility	Robert A. 300 West	Pump	hesda hrey Fy	neral	na Home/
ă	Per Per Per Per Per Per Per Per Per Per	-	1 / 2	he shot	M0033	35   K	ockville, Rockvil	le, M	aryland 20	Mont 85U-∠	omery A	venue,	,
	TO B		23a. Part1. Enter the Isease, shock, or heart failure. List of	om lications that ca only one cause on ea	used the death ach line.	. Do not ent	er the mode of dyin	g, such as c	cardiac or respiratory a	rrest,		Approxima Interval Be	tween
	Physician		Immediate Cause (Final disease or condition	Acute	Myocar	dial	Infarctio	n				Onset and	Death
	/Medical Examiner		resulting in death)	Due to (d	or as a consequ	ence of):							
	±Addinio.	-	Sequentially list conditions, if any, leading to immediate		tensior								
	t t insit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events		tes Mel								
a î	execu in and rial-tra	Exa	resulting in death) Last	G	or as a consequ								
8/60	certificate be executed nding physician and use as the burial-transit	ical		d									
õ	artifica ing ph e as th	Med	IF FEMALE:	T									
X Q Q	atter atter for u	Physician/Me	23b. Was decedent pregnant in the past 12 months?		come of pregnar nth 2 Petal ant at time of de	death 3	Ectopic pregnancy Other (specify)	,		2	3d. Date of deliv. Month	,	Year
o.	0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unkno		au sc							
7	requires that the de leen signed by the a hould be detached t	by Ph	Part II. Other significant condition	ns contributing to de	ath but not resu	Iting in the u	nderlying cause give	en in Part I.	23e. Did 1	obacco us	se contribute to	the cause of	death?
ras	-= " 73								1 🗆	Yes 2	□No 3□Pro	bably 45	Unknown
ecords	S S S	Completed							24a. Was		24b. Were aut	opsy findings	available
r	sicien: The lav certificate has irector, page 2	mo;							perfo	rmed? 2∑No	death? 1 ☐ Yes		240000
Vital	Physicien: this certific ral director.	Be (	25. Was case referred to medical examiner?	Handal			100		of Death (Check only	one)			
01	Physi this o	7	1 ☐ Yes 2 ☑ No  27. Manner of Death	Hospital: 1 ☐ Ir		ER/Outpatier 28b. Time o		4 🗆 1401	sing Home 5 Resi			ify)	
	fing After fune	tlon	1 Natural 5 Pending 2 Accident investig	(Monti	h, Day Year)	Injury	Wor	k? Yes 2⊟N		non injury	00001100		
DIVISION	Attendi r death. sctor: A by the fu	ifica	3 Suicide 6 Could n	ot be 28e. Place	of Injury - At ho	me, farm, str	eet, factory, office		28f. Location ( City or To		d Number or Rui	ral Route Nun	nber,
S	s afte	Certification:	4   Homicide	Bullair	ng, etc. (Specify	/			Chy Gr 70	wii, State)			
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	edical (			sis of examinat				d place, and due to the h occurred at the time,				s)
	To th Withir To th	Me	29b. Signature and title of certifier	0 =			29c. Licens		7 /	-	e signed (Month		
			Suly	real	\	$\bigvee$		487	6	He	e.6.	2001	4
	141		30. Name and address of person of Suresh C. Gupta					03 p.	ockwillo N				
	Sta	ate	31. Date filed (Month, Day, Year)	32. B	egistrar's Signat		roung #2	.559 1(1	OCKVITTE, I				
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DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** DECEMBER 1:36 P M Inez Hunt 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner ST. AGNES HEALTHCAIRE BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 □ M 2 💢 F Yrs. Director 220-14-3054 90 3-29-1914 N.Carolina Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b County 10d. Inside City Limits 27 is marked other than "natural; or Items 23e or 28e-f show traumatic avant. He Medical Examiner must be multiled at 1 Yes 2 No Md. N/A Directo Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 700 N. Woodington Rd. 21229 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Completed by Specify: 3 X Widowed 4 □ Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be fited within 7. h and Mental Hygiene. 7 is marked other then "ns Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Walter William Martha William 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health an Dixon Daugther Audrey 700 N. Woodington Road, Baltimore, Md. 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town. State permit. Pages 1
Department of H
Importent: If ite
any injury or ott 1 Surial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) Md.National Pk. 12-9-04 Laurel, Md. 21. Signature of Funeral Service Licensee

Lloyd M. Estan

22. Name and Address of Facility
Estep Brothers Funeral
1300 Eutaw Place, Baltime

23a. Part1. Enter the bisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Estep Brothers Funeral Ser, P.A. 1300 Eutaw Place, Baltimore, Md. Approximate Interval Between Onset and Death Immediate Cause (Final Physician SEPSIS disease or condition resulting in death) Unknown /Medical Due to (or as a consequence of): Examiner LEFT EXTREMITY GANGRENE unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine use as the burial-transit DIABETTS MELLITUS UNKNOWN that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown þ n signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DISEASE CORONAIRY AKTERY 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 1 ☐ Yes 2₽No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 Tes 2 No this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; After Division Hospital or Attanding 1 Natural Injury 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after deatl 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To tha Funeral C 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Carmila n. mosales, MO marin P18614 DECEMBER 03 2004 MEDICAL INTERN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATON BALTIMORE, MD 21229 AVE MAICIA CAPOLIELA N. POSALES 31. Date filed (Month, Day, Year) 32. Registrar's Signature DEC 1 0 2004 Registrar

1 - For State Registrar State of Maryland / Department of Health and Mental Hygienes Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month JOHNSOZ rurma 015021 December 2004 10:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Genesis Eldercare Hammonds Lane Baltimore Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jan. 25,1910 Birthplace (State or Foreign Country) **Funeral** 1**₫**M 2□ F 94 217 03 8607 Director Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location init. Pages 1 and 2 should be filed within 72 hours after death with the Marylan cutment of Health and Mental Hygiene.
crtant: If item 27 is marked other than "natural", or Items 23e or 28a-f show injury or other traumatic event. The Marylan Examinat must be natified at 10d. Inside City Limits 1X Yes 2 □ No Maryland N/A Baltimore Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3522 Horton Avenue 21225 U.S. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White þ Specify: 3 

Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6th Mechanic Dupont 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ad Johnson Agnes Bathgate 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Kingbrook Court Myril Johnson Son Linthicum, Maryland 21090 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. Cedar Hill Cemetery 12/11/2004 Baltimore, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licenses 4001 Ritchie Highway leone Baltimore, Maryland 21225 manucou 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** on 087 /Medical Due te (orcas a consequence of) Examiner 0 0 06 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infliated events resulting in death) Last Examiner Due to (or as a consequence of): led by the attending physician and detached for use as the burial-transit that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) ☐ Yes 2 ☐ No signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 10 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 9 certificate has autopsy performed 10 1 Yes 2 funeral director. 25. Was case referred to medical 26. Place of eath Check only one, examiner' Other: 2 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 4 Ursing Home 5 Residence 6 Other (Specify) this 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of After t Certification: 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After Injury 1 Natural 5 Pending М 1 Tyes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8,200 who completed cause of death (Item 23a) (Type, Print) Himore, Ald. a 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 1 0 Registrar

**ORIGINAL** 

crn			Amend Item  1- For State Registrar				C	ertifica	te of	Death			Reg. I	C 0	U4	39	136
	Physici	an	1. Decedent's Name (	First, Middle, La	ist)							2. Date of D		Qay _	Year		of Death
	/Media	cal	Nancy K. 4a. Facility Name (If n			-1		45 00	<b>T</b> . 19			Decemb		01, 2			5 A M
0	Examir	ier	1951 Me	rritt Bo	oulevard			D	)unda						ltim	ore	
2	Funeral Director		5. Social Security Num 284-32-05!	50	Sex 1 □ M 2 <b>X</b> F		last birthday 67 Yrs.	Months	Days	If Under 2 Hours	Min.	8. Date of B (Month, I Oct 7,	Birth Day, Yea 19	ar) 37	9. Birth Con Ohio	nplace (State untry)	e or Foreign
J	/land		Usual Residence of D 10a. State 1	Ob. County		10c. City	y, Town or	ocation	*							10d. Inside	City Limits
	a-f sh	ctor	MD	Baltimo	re	Dun	dalk									1 □ Y€	es 2 <b>X</b> No
	or 28	Funeral Director	10e. Street and Numb	er					p Code				10g.	Citizen of W	/hat Coi	intry?	
	eath v	eral	1951 Merri	Ltt Blvd	12. Was Deceden	t Ever in II	C 12	212		lianania Ovia	-2/0	-4. V A		ited :			
36	be filed within 72 hours after death with the Maryland hal Hygiene. Id other then "naturel", or items 23e or 28e-1 show event, the Medical Evanthan must be notified at	by Fun	11. Marital Status  1 ☐ Never Married  3 🛣 Widowed 4	_	Armed Forces  1 Yes 2 If Yes, Give Year or Dates:	? No	.5.			an, Mexican,  Specify:	Puerto i	cify Yes or N Rican, etc.)	10-	Specify.	k, White		
9-0	2 hou		1:	5. Decedent's E	ducation		16a. Dec	edent's Usu	al Occup	ation			16b.	Kind of Bu	Vhit siness/l		
altimore, Maryland 21215-0036	d within 7 jiene. r then "n	Completed	Elementary/Second	only highest gra lary (0-12)	College (1-4or	5+)		etary	ork done use retired	during most	of workir	ng		nance			
pu	al Hyg	BeC	17. Father's Name (Fit	rst, Middle, Last	)					18. Mother	's Name	(First, Middl	e, Maid	en Sumam	θ)		
yla	2 should be f n and Mental I ls marked of reumatic eve	2	Howard Ly							Loret		Botame					
Mar	d 2 sh th and 7 Is m treum		19a. Informant's Nam Sharon Sel									<i>l Route Num.</i> Idalk,				p Code)	
5	Heal Hem 2 tem 2		20a. Method of Dispos	sition		20b. P	lace of Disp emetery, cri				D	ate	-	Location -		own, State	
Itimo	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 Is marked eny injury or other treumatic en <u>once</u> .		1 ☐ Burial 2 🐧 0  4 ☐ Donation 5  21. Signature of Fune	Other (Special		Che	esapea	ke Cr	emat	ory	20	ec 7 004	Bel	Ltsvil	lle,		
Ba	permi Depar Impo eny ir		21. Signature of Turie	- Alla V	no mo	0984						ral Al s Driv		native Baltin		MD	
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68760,	eath certificate be executed attending physician and for use as the burial-transit	_	that initiated events resulting in death) Las	st	Due to (or as	s a consequ	uence of):										
P.O. Box 6	0 0	Physician/Medica	IF FEMALE: 23b. Was decedent printhe past 12 months of 1 west 12 months of 1 west 12 w	onths?	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal	death 3	□Ectopic pi □ Other (sp		,				23d. Date Mon		ery Day	Year
	requires that the	by	Part II. Other significa	ant conditions o	contributing to death	but not resu	ulting in the	underlying o	cause give	en in Part I.						he cause of	
Division of Vital Records,	> ⊥ ∞	Completed										24a. Was auto perf 12 Yes	opsy ormed?	de	ere autorior to consath?	opsy findings impletion of	s available cause of
Vita	Physicien: The lav this certificate has ral director, page 2	o Be C	25. Was case referred examiner?  1 Yes 2 No		Hospital:	00	ED/0		. Othe			Check onl	one				0000
on of		$\vdash$	27. Manner of Death 1 Natural	5 🗌 Pending	Fourthan, Da	ury	ER/Cutpation 28b. Time Found	-	28c. Injun Worl	/ at k?	2	ne 5 Res 8d. Describe	how inj	jury occurre	d		cene
Divisio	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funerel Director After this certific completely filled in by the funeral director.	Certification:	2 ☐ Accident 3 🕻 Suicide 4 ☐ Homicide	investigation 6 Could not be determined	6 1Z-1-ZU		10:29 me, farm, s	A		Yes 2 XXN	2	ibject  Bf. Location City or To  indalk	(Street a	and Numbe ite) 195			Blvd
	ne Hospite 124 hours ne Funerel Hetely fille	edical C	29a. Certifier 1[ (Check only one)	Certifying Ph Medical Exar	nysician: To the best miner: On the basis of and manner st	of examinat	wledge, dea ion and/or i	th occurred ivestigation	at the tim	ne, date and pinion, death	nlace a	nd due to the	rausol	(c) and man	ner as s	tated.	(s)
	To th withir To th	M	29b. Signature and tith	e of certifier				290	c. License				29d. D	ate signed	(Month.	Day, Year)	
1			▶ Ch	rest 2					0.	C.M.E	•		Dec	ember	02,	2004	
	(0)		30. Name and address	A RU	10, HD		113	Penr	ı Str	eet, l	Balt	imore,	Ma	rylan	d 21	201	
8	Sta Registr	-	31. Date filed (Month,	Day, Year)	2004 32. Regist	rar's Signat	ture /	bod	ر								

Nancy Kay Johnson

		•	For Amend Ite 1 - State Registrar	m 18Stpterofi	Ma <b>6838</b> d1 <b>Da</b> Ce	Our Ordentiace ertificate o		nd Mental Hy	giene 2004	39137
	Physici	an	1. Decedent's Name (First, Middle	Last)				2. Date of De	aath Day Year	3. Time of Death
	/Medi		CHARLES JOHNSO					DECEMB	ER 2, 2004	4pm M
4	Examir	ier	4a. Facility Name (If not institution,		ber)		n, or Location of	f Death	4c. County of Dea	ath
	Funeral		JOSEPH RITCHII  5. Social Security Number		'. Age (In yrs. last birthda		IMORE ar   If Under 2	4 Hrs. 8. Date of Bir	N/A	rtholace (State or Foreign
	Director		215-24-1097	1 <b>X</b> □M 2□F	89 Yrs.	Months Da	ys Hours	8. Date of Bin (Month, Date 2-1-19	ay, Year) C	rthplace (State or Foreign Country) RYLAND
	pu *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or I					
	Aarylan I show	ō	MD. ANNE AI	RUNDEL	SEVERNA I					10d. Inside City Limits 1 XYes 2 No
	the 7	Director	10e. Street and Number		52,233	10f. Zip Cod	le		10g. Citizen of What C	
	h with	를 교	105 DENNIS RD			211	46		USA	•
	ems	Funeral	11. Marital Status	12. Was Deced	lent Ever in U.S. 13			in? (Specify Yes or No Puerto Rican, etc.)		
36	ours after death with the Maryla al', or Items 23a or 28a-1 shov Evan inventional condification	by Fu	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 ☐ Yes 2 If Yes, Give	No No	1 ☐ Yes 2 ☐ X			Specify: BI	
9	72 hours after death with the Maryland "natural", or Items 23e or 28e-1 show adical Exandrac must be routiled at		15. Decedent	Year or Dat s Education		edent's Usual Oc	cupation		16b. Kind of Business	
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21	filed withir Hygiene. Ithar than	Com	-9-	-0-		UNDKEEP			PRIVATE I	
and	be d tal	Be	17. Father's Name (First, Middle, L						, Maiden Sumame) 🖰	NK.
Maryland 21215-0036	2 should be and Mental is markad is markad raumatic av	2	THOMAS JOHNSO		10h Mai	ing Address /Ct-		ie Gvieo		7 0 11
Ma	s 1 and 2 should f Health and Men itam 27 is marks other traumatic		AGNES COATES (I						er, City or Town, State, MARYLAND	
ē,	es 1 and of Health fitam 27 r other tr		20a. Method of Disposition		20b. Place of Disp	* ***	1	Date	20c. Location - City or	
E			1  Burial 2  Cremation  1  Donation		ASBURY TO	DWN NECK	11	2-7-2004	SEVERNA PAR	K, MARYLAND
Baltimore,	permit. Page Department Important: If any injury o		21. Signature of June al Service L	icensee	CHURCH	CEMPYER.	ress of Facility	WM. REESE	& SONS MORT	UARY P.A.
	205 20		Jany	Vees	2	21 WEST	ST. AN	NAPOLIS, M	ARYLAND 214	01
			23a. Part1. Enter the dise te, or o shock, or heart failur. Ust o	complications that cau inly one cause on ear	used the death. Do not en ch line.	1 .	4		rrest,	Approximate Interval Between Onset and Death
	Physician /Medical	K W	Immediate Cause (Final disease or condition resulting in death)	a	Metasta	lic co	lon C	ancer		weeks
	Examiner				r as a consequence of):					
	<b>7</b> +	ner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury	Due to (or	r as a consequence of):					7
Vit	acuted Ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						1
8760,	cate be executed oblysician and the burial-transit	E	resulting in death) cast	Due to (or	r as a consequence of):					
687	icate physi s the l	dlcal		d						
Вох (	eath certific attending pl for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		ome of pregnancy				23d. Date of de	livery
	ō o ō	lcia	in the past 12 months? 1 ☐ Yes 2 ☐ No		nt at time of death 5	⊒Ectopic pregna ⊒ Other (s <i>pecify)</i>			Month	Day Year
P.0	requires that the sen signed by the	Phys	9 Unknown							
	w requires that been signed to should be det	by	Part II. Other significant condition	is contributing to dea	th but not resulting in the	inderlying cause	given in Part I.		obacco use contribute to	the cause of death?
Sor	v requ been s rouk	etec								
Records,	has e 2	Completed						— 24a. Was autor perfo	an 24b. Were as prior to death?	utopsy findings available completion of cause of
7 <u>a</u>	en: The tificate l	a	25. Was case referred to medical				26 Place o	1 ☐ Yes	2 2 No 1 ☐ Yes	2 No
Ϋ́	nding Physician: th. : After this cert fica s funeral director, s	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inp	patient 2 ER/Outpatie	nt 3 DOA	Othor	sing Home 5 Resid		oHospice.
O L	ng Ph	on:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of (Month,	Injury 28b. Time Injury	of 28c. In			now injury occurred	
Sio	Attanding r death. ector: After by the fune	icat	2 Accident investigation in Accident in Accident investigation in Accident i		A laine At han a fair		☐Yes 2☐No			
Division of Vital	l or Al after Direc	Certification;	4 Homicide determin	ned 286. Place of building	f Injury - At home, farm, s p, etc. (Specify)	reet, factory, offic	C <del>O</del>	City or Tov	Street and Number or Ri vn, State)	ural Houte Number,
	spita nours naral / filled		29a. Certifier 1 Certifying	Physician: To the b	est of my knowledge, dea	th occurred at the	time, date and	place, and due to the	cause(s) and manner as	s stated.
	To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	(Check only 2 Medical E	xaminer: On the bas and manne	is of examination and/or in	vestigation, in m	y opinion, death	occurred at the time.	date and place, and due	to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	-		29c. Lice	ense number		29d. Date signed (Mont	
•		-	212	OM)			D241	10	December	2,2004
	1		30. Name and address of person w	Richey	Hospice	838 1	V.Eu	tawst [	Baltimore	2,2004 MD 21201
	Sta Registr	4 79	31. Date filed (Month, Day, Year)	004	gistrar's Signature	Span				

			1 - For State Registrar	•	artment of Health and Nartificate of Death	fental Hygie. Reg.	2006	39139
			Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
	Physici /Medio		MARY JOAN	KUTZ		DECEMBER	4, 2004	6:00 PM
	Examir		4a. Facility Name (If not institution, give street Saint Joseph Me	dical Center	4b. City, Town, or Location of Death	on	4c. County of Death Ealt	imore
ŀ	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Ye	ar) Coun	lace (State or Foreign try)
	and *		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation	1	11	Od. Inside City Limits
	f sho	5		Pagy.	111-			1 ☐ Yes 27 No
	r 28a	Director	10e. Street and Number	PARM	10f. Zip Code	10g.	Citizen of What Coun	try?
	h with		22.28 Mills RS.55	Av	21234		12.5.A.	
	ems ems	Funeral	11. Marital Status 12. V	Vas Decedent Ever in U.S. 13. med Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "natural", or items 23a or 28a-f show other then "natural", or items 23a or 28a-f show event, the Medical Examinat must be notified at	by Fu		☐ Yes 211 No Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify:	
8	2 hour	ed t	15. Decedent's Education	n   16a. Dece	edent's Usual Occupation	166	. Kind of Business/Inc	dustry
21215-0036	within 72 ene. then "na	Completed	(Specify only highest grade con Elementary/Secondary (0-12)	npleted) (Giv. life.	e kind of work done during most of work DO NOT use retired)	ring		,
7	filed withi Hygiene. Ither ther	Con	12YRS-		MEMAKER		AT Hom	2
Maryland		Be	17. Father's Name (First, Middle, Last)	100 · · · · · · · · · · · · · · · · · ·	18. Mother's Nam	e (First, Middle, Maid	den Sumame)	
7	d 2 should be th and Mental 7 is marked o traumatic eve	은	19a. Informant's Name/Relationship (Type, F	SIYMOUR 19b Mail	ing Address (Street and Number or Flyr	ral Boute Number, Ci	ty or Town State Zio	Codel
	ith ar 11th ar 27 ts r trau		STANLEY J. KUTZ	2910	Harrist Avs A	1/2 XXX	Median	2 21234
re,	- I 6 =		20a. Method of Disposition	20b. Place of Disp		Date 200	. Location - City or To	wn, State
imo	Pages nent of I ant: If Its ury or o		17⊈ Burial 2 □ Cremation 3 □ Remove 4 □ Donation 5 □ Other (Specify)	val from State	LARTOF JEGUS AT	100	MALLA M	arylano
Baltimore,	permit. Pag Department Important: i any injury o		21. Si manire ef Funeral Service Licentee	S	2. Name and Address of Facility	Esissoms	~	
	#0 E E 9		Crop Trans		8800 MARFORD POPE	O AARWIJ	75/1JUSYE	resis on
Н			23a. Part1. Enter the disease, or complication shock, or heart failure. List only drie call immediate Cause (Final	use on each line.	iter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	SEPSIS				
	Examiner	Н		Due to (or as a consequence of): METASTATIC BRE	EAST CANCER			
	/ <del>-</del> -	ner	Sequentially list conditions, lany, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):				
VI	ecuted ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last					
8760,	cate be executed only sician and the burial-transit	E	resulting in death) cast	Due to (or as a consequence of):				
687	physi physi s the l	edicai	d					
). Box (	The law requires that the death certificate be executed as been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ry Day Year
P.0	that the de led by the a detached	Phy	9 ☐ Unknown  Part II. Other significant conditions contribu		underhing grupe given in Part I	23a Did tobace	co use contribute to th	a cause of death?
ds,	uires tha signed Id be de	1 by	Part II. Other significant conditions continue	ting to death out not resulting in the	underlying cause given in Fait i.	1 Yes	2 No 3 Prob	
Vital Records,	w requ	Completed				24a. Was an	24h Were autor	osy findings available
Be	The lav	dmo				autopsy performed	prior to cor death?	npletion of cause of
tal		a	25. Was case referred to medical		26. Place of Deat	1 ☐ Yes 24 h (Check only one)	No 1 ☐ Yes	2 No
Ţ	S S	To B	examiner? 1 ☐ Yes 2 📉 No Hospi	tal: 1 X Inpatient 2 ☐ ER/Outpatie	Other		e 6 □Other (Specify	')
n of			27. Manner of Death 1 X Natural 5 ☐ Pending	Ba. Date of Injury 28b. Time (Month, Day Year) Injury	of 28c. Injury at Work?	28d. Describe how in		
Sio	Attendir death. ctor: Al y the fu	icati	2 Accident investigation 3 Suicide 6 Could not be	Be. Place of Injury - At home, farm, s	M 1 Yes 2 No	28f Location /Strong	t and Number or Rura	I Pouto Number
Division	al or Attendir s after death. al Director: Al	Certification:	4  Homicide determined	building, etc. (Specify)	reet, factory, office	City or Town, Si	tate)	riodie Namber,
_	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: Afte completely filled in by the fune	Medical C	(Check only 2 Medicel Exeminer:	n: To the best of my knowledge, dea On the basis of examination and/or i	th occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the cause red at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
	omple	Mec	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month, I	Day, Year)
	->-0		> czaginda P Me	Ata m.o	D 41410	De	eember of	47/2004
	1/1		30. Name and address of person who comple	eted cause of death (Item 23a) (Type	, Print)			
	13		JOGINDER P. MEHT		OSLER DRIVE, TO	DWSON, M	ARYLAND :	21224
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signature	land 1			
	negist	rui	DEC 1 0 2004	Depict C	MOUNT			

Physicia	an	Decedent's Name (First, Middle,	Last)	· a	77 . 1	2. Date of Month				200 Year	3. Time of Death
/Medic	al	Kenneth  4a. Facility Name (If not institution)		S. Kulick			15.0	DECEMBE		8,2004 2:30P.	
Examin	er	12905 MARQUETTE	LANE	ANE		4b. City, Town, or Location of Death BOWIE  If Under 1 Year   If Under 24 Hrs.			PRI	4c. County of Death PRINCE GEORGES	
Funeral Director		5. Social Security Number  577–72–9922  Usual Residence of Decedent	6. Sex 1 2 F 7.	Age (In yrs. last birtl		Days Hou	der 24 Hrs. rs Min.	8. Date of Birth (Month, Day Feb. 9	, Year) , 195	53 Pe	hplace (State or Foreign untry) ennsylvania
ryland how		10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ont, the Medical Examinat must be multiled at	Director	Maryland Prince	e Georges		Bowie						1. Yes 2□No
3a or 3	i Dir	10e. Street and Number  12905 Marquette	Lane		10f. Zip (	20715			_	en of What Co nited S	•
r death	Funerai	11. Marital Status	12. Was Decede		13. Was Decede		Origin? (Sprican, Puerto	ecify Yes or No-		I. Race - Amer Black, White	rican Indian,
s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. If Health and Mental Hygiene. If Health and Mental Hygiene. Other is marked other than "natural", or items 23a or 28a-f show other traumatic svent, I'm Medical Exam national to molified at	by	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ ∰Pivorced		<b>X</b> No	1 ☐ Yes 2						White
"natu "natu edical	letec	15. Decedent's (Specify only highest		16a. I	Decedent's Usual (Give kind of work life. DO NOT use	c done durina r	nost of work	ing		of Business/l	*
giene. er than	Completed	Elementary/Secondary (0-12)	College (1-4)	or 5+)	Salesma	,			-	plianc	
be filed ntal Hygi od other svent, I	Be	17. Father's Name (First, Middle, La				18. M		(First, Middle,		,	
and Mental is marked of raumatic sve	Jo .	Harry Ki  19a. Informant's Name/Relationshi	ulick	19b.	Mailing Address (	Street and Nu	Lilli mber or Bura		skura		in Code)
and 2 salth ar 27 is er trau		Lillian Kulick.		- Italia							and 21037
permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other tra once.		20a. Method of Disposition  1 1 1 Cremation 3 1 Other (Special Control of Con	3 □Removal from Sta	20b. Place of cemetery	Disposition (Name y, crematory or oth hn's Cem	e of ner place)		Date	20c. Loca	ation - City or 7	Town, State <b>Sylvania</b>
oortan oortan injur	Ì	21. Signature of E		DE. 30		-	1				H., Inc.
Depa Impo any ir		> www pota	W - M	01113	621–29	Main Si	Jos treet.	epn w. 3 Simpson	n. Pe	enias r ennsvlv	.н., inc. ania 18407
		23a. Part1. Enter the disease, or co shock, or heart failure. List or	complications that cause on each	sed the death. Do no	ot enter the mode	of dvina, such	as cardiac o	or respiratory arr	est.		Approximate
Physician /Medical		Immediate Cause (Final		i midi		, ,,		, –			Interval Between
		disease or condition		clerotic	Cardiova						Interval Between Onset and Death
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State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** WILLIAM E. November 26,2004 6:20p/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Gardens Nursing Ctr. Baltimore
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Mary Land

9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 1**X** M 2□ F 216-16-3154 80 Director 08/04/1924 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23e or 28e-f show traumatic event, the Modical Examinan must be notified at Yes 2 No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 751 Saratoga St. USA Funeral Apt 313 21223 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Marned Maryland 21215-0036 1 ☐ Yes 🏋 No Specify Specify: BLACK q 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 Is marked other than VETERANS HOSPITAL 12 NURSING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Kess ဂ္ Della Iona 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3015 Echodale Ave., Geraldine Brandon (Daughter) 3015 Echoda
20a. Method of Disposition (Name of cemetery, crematory or other place) Balto.,MD 21214 Baltimore, 20c. Location - City or Town, State 5 Other (Specify) Garrison Forest 12/03/2004 Owings Mills, MD 22. Name and Address of Facilities Redd Funeral Service 21. Signature of Funeral Service Lice 1721-27 N. Monroe St., Balto., MD 21217 23a. Part1. Enfort the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate use (Final disease or condition resulting in death) lumoma Physician /Medical Due to for as a consequence of): Examiner wing disease Sequentially list conditions, Examiner in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events arcinom and resulting in death) Last Due to (or as a consequence of): the attending physician a hed for use as the burial-Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year 5 Other (specify) P.O. 1 detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Records, page 2 should be 2210 1 ☐ Yes 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed? 1 Yes 2 No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 ☐ Yes 2 No 2 4 ursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury all Work? 28d. Describe how injury occurred Certification: After Division Natural 5 Pendina 1 ☐ Yes 2 ☐ No М death. 2 Accident investigation within 24 hours after death To the Funerel Director: filled in by the 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 90 29b. Signature and fittle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601-Loch Kaven 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 0 9 2004 Registrar

**ORIGINAL** 

			For State Registrar	State of Maryland		artment of I				iene 20	04	39162
	Physic /Medi		1. Decedent's Name (First, Middle, Last)	ZALA					Date of Dear	th Day	Year 204	3. Time of Death
	Examii Funeral Director		4a. Facility Name (If not institution, give styles of the facility Number of Security Number of Sex 219–14–1576	reet and number)  IEX Cent  7. Age (In yrs. last  7. Age 7	eL birthday) Yrs.	4b. City, Town,  If Under 1 Year  Months Days	771 If Under	24 Hrs. 8.	Date of Birth (Month, Day, lay 12,	4c. county (	9. Birthpla Count	MONE  ace (State or Foreign try)  vland
	D.		Usual Residence of Decedent  10a. State  10b. County	10c. City, T					1ay 12,	1925		Od. Inside City Limits
	with the M a or 28a-f be notifie	Directo	MD N/A  10e. Street and Number		Bal	10f. Zip Code			1	0g. Citizen of W		
920	uges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mentat Hygiene.  If item 27 is marked other than "naturel", or Items 23a or 28a-f show or other traumatic event, the Madical Examinational be notified at	by Funeral Director	1009 South Bouldin  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	. Was Decedent Ever in U.S. Armed Forces?  1 Tyes 2 No If Yes, Give Year or Dates:		Was Decedent of I f Yes, specify Cub I ☐ Yes 2 🔀 No		gin? (Specif n, Puerto Ric	y Yes or No- an, etc.)	Black	State American K, White, e	an Indian, etc.
21215-0036	d within 72 ho giene. er than "natur. i tre Medical i	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	tion 1- completed) 1-College (1-4or 5+)	(Give life. L	lent's Usual Occu kind of work done DO NOT use retire eel Work	during most	t of working		16b. Kind of Bus		
Maryland	should be filed ind Mentat Hygi s marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) Anthony Kacala				1		irst, Middle, A la1kows	Maiden Sumame ka	,)	
Mar	12 sho h and 7 is mu Iraum		19a. Informant's Name/Relationship (Type			g Address (Street						•
Baltimore, I	perrit. Pages 1 and 2 Department of Health Important: If item 27 any njury or other tra once.		Patricia A. Daugher  20a. Method of Disposition  1 XBurial 2 Cremation 3 Rer  4 Donation, 5 Other (Specify)	noval from State	of Dispos etery, cren	O Westcl sition (Name of natory or other pla islaus C	ice)	r. Pa Date 12/8/0	2	, Maryl 20c. Location - C altimor	City or Tow	vn, State
Baltin	perr it. Pag Department Important: I any njury o once.		21. Signatura Funeral Service Licensee		22 C	Name and Addre harles S 224 East	ess of Facility • Zeil	ler &	Son, I	Nc.		
	The law requires that the death certificate be executed XX XX XX XX XX XX XX XX XX XX XX XX XX	edicai Examiner	23a. Part1. Enter the disease, or complications shock, or bart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d	Due to (or as a consequent  Due to (or as a consequent  Due to (or as a consequent  Due to (or as a consequent	ce off:	er the mode of dyi	OM	R (j	MALL ADV	CEUD) Inc revrys,	in C	Approximate Interval Between Onset and Death
.O. Box 6	that the death certific ed by the attending p detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of pregnancy  1 Live birth 2 Fetal dea  4 Pregnant at time of death 9 Unknown		Ectopic pregnanc Other (specify)	у			23d. Date Mont	of delivery	y Day Year
Ω.	w requires that the been signed by should be detact	by	Part II. Other significant conditions contr	buting to death but not resulting	g in the un	derlying cause giv	ven in Part I.				bute to the	cause of death?
Vital Records,		e Completed	25. Was case referred to medical						24a. Was an autopsy perform	led? de	or to comp eath?	sy findings available pletion of cause of
>	Physicien: this certificatal director,	OB	examiner?	spital: 1 patient 2 ER/	Outpatient	3□ DOA Ott			heck on one	nce ,6 Other	(Specify)	
Division of	ding After fune	Certification; T	27. Manner of Death  1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	Time of Injury	28c. Injur Wor M 1 □	ry at rk? ∣Yes 2 □ N	28d.	. Describe how	w injury occurred	d	
Divi	pital or Attendous after death ours after death eral Director: filled in by the		4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)					City or Town,			
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical	(Check only one)  2   Medical Examine  29b. Signature and title of certifier	ian: To the best of my knowled r: On the basis of examination and manner stated.	and/or inv	estigation, in my o	эріпіоп, ават	d place, and th occurred a	it the time, da	use(s) and mani te and place, an d. Date signed (	a due to tr	ne cause(s)
)	1/1		30. Name and address of person who com	pleted cause of death (Item 23a	2) (Type, F	05	03-6	5	a	ecemi	ber	3,2004
	111		31. Date filed (Month, Day, Year)	MOSOI ST PX	W.	PL B.	OCT.	IMO	ME,	MD	2	1202
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			For	State of Marylan					_ ^	0.01	0011	^
			State Registrar	41	Cei	tificate of	Death	2. Date of Dea		<u>UU4</u>	3914	3
	Physicia	ın	1. Decedent's Name (First, Middle, L	CHARL	ES	LEE		Month DEC	Day	yea 20	3. Time of De	eath 1 M
	/Medic Examin		4a. Facility Name (If not institution, gi				r Location of Death		4c.	County of D		
	LXdillill	٠,	MANOR CARE O	F WOODBRIDGE	VALLEY	CA	TONSVI	LLE		BA	LTIMOR	25
	Funeral			Sex 7. Age (In yrs. )	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birti		9. [	Birthplace (State or F	oreian
	Director	4	Usual Residence of Decedent	VIII 201	Yrs.			DEC. 00	2/19	26 M	Country) IARYLA	NO_
	show		10a. State 10b. County	10c. City	y, Town or Lo	cation					10d. Inside City	Limits
	the Mar 28e-f sh	ctor	MARYLAND /	NIA		BAL	TIMOR	E CI	TY		1 ⊠Yes 2	□No
	or 28	Directo	10e. Street and Number	0 - 6		10f. Zip Code			10g. Citiz	zen of What	Country?	
	death with the Maryland ms 23a or 28e-f show	erai	7015 W.	KOGERS A	VENUE		2121			U Bass A	SA. merican Indian,	
_	after death w or itams 23a	Funeral	11. Marital Status  1 ☐ Never Married 2 Married	Armed Forces? 1 NYes 2 □ No			dispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		Bleck, W		
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Z	within ene. than "	duc	Elementary/Secondary (0-12)	College (1-4or 5+)	ine. i	JANI	_	4	SHA	EPHE	EN PRA	7-
פו	other ent,	e C	17. Father's Name (First, Middle, Las	st)		,,,,,,,,,	18. Mother's Nam				10/10	•
ylar	Menta Menta arked	To Be	JAMES	L	EE		LIDA			CL	ARK	
Mar	12 sho		19a. Informant's Name/Relationship		19b. Mailir	ng Address (Street	and Number or Rui		- 4			
a) (a)	s 1 and 2 should f Health and Mer itam 27 is marke other traumatic		20a. Method of Disposition	= (WIFE)	lace of Dispo	sition (Name of		Date Date			10. 2/2 or Town, State	4/5
	96 = 5		1 Burial 2 □ Cremation 3 '4 □ Donation 5 □ Other (Spec	I IHAMOVALITOM STATA I		natory or other plac	TERY 12-	18-04			HILL M	• ^
Sait	mit. Pa partmen portant: / injury 28.		21. Signature of Funeral Service Dice	ensee	22	Name and Addre	ess of Ficility	Benezal			ERAL H	tom
ă	permi Depar Impor any ir			10	1 3	2145 N	FULTO	NAVE	.6	ALTO,	MD 213	217
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	mplications that caused the death y one cause on each line.	n. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory ar	rast,		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a//\/\tau	testati	e lune	, ancis	ume			Conset and Dea	2
	/Medical Examiner		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Due to (or as a consequ	uence of):		1					
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XOR	that the death certificate ed by the attending physidetached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		15			2	3d. Date of	delivery	
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ecord	2 D 0	iete	Sun	use disorder				24a. Was a	ลก	24b. Were	autopsy findings ava	ailable
r	i <b>ician:</b> The lav certificate has rector, page 2	Completed		- W ( W ) ( ) ( W )				autop: perfor	med?/	prior t death 1 □ Y	to completion of caus ?	se of
	ysician: is certifica director, p	BeC	25. Was case referred to medical examiner?				26. Place of Deat				03 22 110	
0 0	Physician: this certificinal director,	၉	1 ☐ Yes 2 ☐ No	Hospital: 1   Inpatient 2			4 Nursing no	ome 5 Resid			pecify)	
S S	ding Phys h. After this ( funeral dir	ion:	27. Manner of Death  1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	yat k? Yes 2 □ No	28d. Describe h	ow injury	occurred		
UIVISION	Attended death	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location				28f. Location (S	n (Street and Number or Rural Route Number,			r,	
5	s after s after al Dire	Cert	4 Homicide building, etc. (Specify)						n, State)			4
	Hospi 4 hour Funar ely fill	edical	(Check only 2 Medical Exe	Physicien: To the best of my known in the basis of examination of the basis of examinations.	wledge, death tion and/or inv	occurred at the tir	me, date and place, pinion, death occur	and due to the d	ause(s) a late and	and manner place, and c	as stated. lue to the cause(s)	
	To the Hospitel or Attending within 24 hours after death. To tha Funaral Diractor: After completely filled in by the fune.	Med	one)  29b. Signature and title of contifier	and manner stated.		29c. Licens					onth, Day, Year)	
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T	1/1		30. Name and address of person who	ocompleted cause of death (Item		Print)						
(	4,		15/12/	Ilt leman	1838	Weln	e ru	Old	~	1208		
	Sta Registr		31. Date filed (Month, Day, Year)  DEC 1 0 20	32. Registrar's Signar	G	Sparks	e Tru					

			1 - For Unpend Item Registrar	23State of Maryla	and/Depa per me Cer	tificate of L	ealth and M Death	ental Hygie	ene 004	39144
	Physici /Medio		1. Decedent's Name (First, Middle, La	INDSEL				2. Date of Death Month December	Day Year	3. Time of Death 12:44 A. M
	Examir		4a. Facility Name (If not institution, giv			4b. City, Town, or	Location of Death		4c. County of Dea	jn
00			Good Samaritan Ho			Baltir				A
172	Funeral Director		213 00-1101 -	ex 7. Age (In y	rs. last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) July 16,	9. Bin 1953	thplace (State or Foreign ountry)
7	land		Usual Residence of Decedent  10a. State 10b. County	- 10c.	City, Town or Loc	ation				10d. Inside City Limits
	Mary	to	MD BAL	TIMORE		PARKUI	lle			1 ☐ Yes 2 No
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 ie marked other then "natural", or iteme 23e or 28e-f ehow other traumatic event, the Medical Examinat must be notified at	ai Director	10e. Street and Number 6830 Old	HARFORD R	S.	10f. Zip Code	1234	100	g. Citizen of What Co	,
	ame arme	Funerai	11. Marital Status	12. Was Decedeni Ever in Armed Forces?		as Decedent of His Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto I	cify Yes or No-	14. Race - Ame Black, Whit	erican Indian,
5-0036	ours afte	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Oïvorced	1  Yes 2 No	U-5-	□Yes 2□No	Specify:	,	Specific	hite
5-0	72 h	Completed	15. Decedent's E (Specify only highest gra	ducation ide completed)	16a. Deced	ent's Usual Occupa	ntion luring most of workir )	16	6b. Kind of Business	/Industry
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9	filed v Hygie ther i		17. Father's Name (First, Middle, Last	NIA			18. Mother's Name		3	THEFT CORP
an an	id be ental ked o	To Be	Frederick	LINDSEN :	5R		ANNA	DIETE		
Maryland	2 should be filed within and Mental Hygiene. ie marked other then aumatic event, the Mi	-	19a. Informant's Name/Relationship (		19b. Mailing	Address (Street a			City or Town, State, 2	Zip Code)
	1 and 2 Health a tem 27 ic		ANNA DIETRI	it LINDSEL	1 682	o old h	affered pr	D. Bo 17	to. Ms 2	1234
ore			20a. Method of Disposition  ☐ Burial 2 ☐ Cremation 3 ☐		cemetery, crem	ition (Name of atory or other place	۱ اه		c. Location - City or	
Ĕ	Pag ment ant: i		'4 □ Donation 5 □ Other (Specil	y) 6	Ardens .	of frith	12/10	104 1	Bulto M	2 .
Baltimore,	permit. Page Department of Important: If eny injury or once.		21. Signature of Funeral Service Licer	Sitelle	22. H	Name and Address ART(24 M	s of Facility 57	ella 40 Balto.1	nerallton	NE CHTO
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that coused the de						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	, Hypertensiv	ve Cardi	ovascular	Disease			Onset and Death
	/Medical		resulting in death)	Due to (or as a cons		7.0500101	2230000			
	Examiner	_	Sequentially list conditions,	b						
	led nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	sequence of):					
	ificate be executed g physicien and as the burial-transit	хап	that initiated events resulting in death) Last	c. Due to (or as a cons	sequence of);					
68760,	sicier sicier	aiE		d						
89	- CD #	edicai	100	. u.						
P.O. Box	To the Hospital or Attending Physicien: The law requires that the death certif within 24 hours after death.  To the Funeral Director: After this certificete hes been signed by the ettending completely filled in by the funeral director, page 2 should be delached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pred 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	etal death 3 🔲	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
	s that ned b e deta	by Pi	Part II. Other significant conditions of	ontributing to death but not i	resulting in the un	derlying cause give	n in Part I.	23e. Did toba	cco use contribute to	the cause of death?
rds	v require been sig should b		Liver Cirrhosis					1 ☐ Yes	2 □ No 3 □ Pr	obably 4 Unknown
Records,	hyelcien: The law re his certificete hes ber I director, page 2 sho	Completed						24a. Was an autopsy performe	d? prior to death?	itopsy findings available completion of cause of
ital	ien: intifice ctor, p	Bec	25. Was case referred to medical examiner?				26. Place of Death		1,00	2010
.\ <u>`</u> ≥	Phyelc this ce al direc	10 1	1 □X'es 2 □ No	Hospital: 1 ☐ Inpatient 2	ER/Outpatient	3□ DOA Othe	r: 4 🗆 Nursing Hom	e 5 🗆 Residenc	ce 6 Other (Spec	cify)
It, o	ding Pl J. After tl funera	on:	27. Manner of Death  1    Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		8d. Describe how	injury occurred	
sio	tending Ph leath. tor: After th the funeral	cati	2 Accident investigation 3 Suicide 6 Could not b				es 2 □No			
Division	or At after of Direct in by	Certification:	4 Homicide determined		i home, farm, stre ecify)	et, factory, office	2	City or Town, S	et and Number or Ru State)	iral Houte Number,
	To the Hospitel or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	edical Ce	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exer	ysicien: To the best of my k niner: On the basis of exam	knowledge, death	occurred at the time	e, date and place, a	nd due to the caus	se(s) and manner as	stated.
	To the h within 24 To the f complete	Med	29b. Signature and title of certifier	and manner stated.		29c. License				` '
	Q - Z	-	> Za Luiel	tale Al		OCM			Date signed (Mont) ecember 8	
1	) Selec	7	30. Name and address of person who ZABILILL	HALI	1		Street, B	altimore	, Maryland	d 21201
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sig	gnature					
	Registr	ar	DEC 1 0 2004	Blocker B	A 10040					

			State of Mai	ryland /	Department of H		ental Hygi	ene	00115
		-	Registrar  1. Decedent's Name (First, Middle, Last)		Certificate of I	Death	2. Date of Death	g. NE UU4	39145 3. Time of Death
	Physici /Medio		-1 1	awrenc	re		Month / 2	Day Year	
	Examir		4a. Facility Name (If not institution, give street and number)	- (		r Location of Death		4c. County of Dea	<del></del>
			5. Social Security Number 6.5 Sex 17. Ade	(In yrs. last b	Kose,	A / G If Under 24 Hrs.	P. Data of Righ	13A//i	MORE
	Funeral Director		5. Social Security Number ( 6. Sex 7. Age 216-28-7624	70	Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day, 12/28/1	Year) 9. Bli	nthplace (State or Foreign ountry) Vland
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City. Tox	wn or Location			700   1141	10d. Inside City Limits
	Maryl	tor			e River				1 ☐ Yes 2X No
	ours after death with the Marylar rel', or Items 23a or 28e-f show Examiner ovet be notified at	Directo	10e. Street and Number	MICCIE	10f. Zip Code		10	g. Citizen of What C	ountry?
	sath w	eral	9 Nacelle Road  11. Marital Status 12. Was Decedent Ev		21220		υ	J. S. A.	
0	after d ir Item direr	Funeral	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ Nover Married 2 ☐ Married 1 ☐ Yes 2 ☐ Nover Married 2 ☐ Married 1 ☐ Yes 2 ☐ Nover Married 2 ☐ Nover		13. Was Decedent of Hi If Yes, specify Cuba		Rican, etc.)	14. Race - Am Black, Whi	
003		d by	3 Widowed 4 □ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify:	White
215-0036	be filed within 72 ho tal Hygiene. d other then "natu event, Ire Modical	Completed	15. Decedent's Education (Specify only highest grade completed)		a. Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired	ation during most of workin ()	g 1	6b. Kind of Business	/industry
_	filed within Hygiene. wher then "	Com	Elementary/Secondary (0-12) College (1-4or 5+)		ruck Driver			teel	
Maryland 2		Be	17. Father's Name (First, Middle, Last)			18. Mother's Name			
Ž	should nd Men marke umatic	٩	Freddie Francis Montgomery :  19a. Informant's Name/Relationship (Type, Print)		WYENCE b. Mailing Address (Street a	Marie He			Zin Code)
	s 1 and 2 should f Health and Mer item 27 Is marke other treumatic		Regina Marie Feyjoo (Daught		815 Harbin e			, Marylan	
ore or	00		20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State	20b. Place of	of Disposition (Name of ery, crematory or other place	l Da		Oc. Location - City or	
gaitimore,			` 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	Bayvi	ew Crematory		В	altimore,	Maryland
n	permit. Departr Imports any inj		Malad C Sallas S		Bruzdzinsk 1407 Old E	i Funeral	Home PA	COV Marti	land 21221
			23a. Part1. Enter the disease, a complications that caused the shock, or heart failure. List only one cause on each line.	e death. Do	not enter the mode of dying	g, such as cardiac or	respiratory arres	st,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		schemia				Onset and Death
	Examiner		Due to (or as a d	consequence	of):				
ı	p tis	iner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	consequence	of):				
4	be executed sician and burial-transit	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last  C. Due to (or as a continuous properties)	consequence	of):				
2/60	cate be executed bhysician and the burial-transit	cal	d	,					
õ	certifica nding ph use as th	Medi	IF FEMALE:						
X Q	atte for I	Iclan/Me	23b. Was decedent pregnant in the past 12 months?  1 Veg. 2 No. 1 No. 2	Fetal death	h 3 Ectopic pregnancy 5 Other (specify)			23d. Date of dei Month	livery Day Year
j.	at the di by the tached	hys	1 Yes 2 No 4 Pregnant at tin 9 Unknown 9 Unknown		CE Carrol (opecan))				
1S, 1	v requires that the dibeen signed by the should be detached	l by P	Part II. Other significant conditions contributing to death but	not resulting i	in the underlying cause give	on in Part I.			the cause of death?
cords,		ompleted					24a. Was an		robably 4 Unknown
r	9 4 9	omo					autopsy performe	prior to	utopsy findings available completion of cause of
VII	Physician: Th this certificate ral director, pag	BeC	25. Was case referred to medical examiner?			26. Place of Death	Check on one		
5	Phys this al dii	): To	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 27. Manner of Death 28a. Date of Injury	28b.	utpatient 3 DOA  Time of 28c. Injury Injury  Othe	4 Nursing Home	e 5 Residen	ce 6 □Other (Specinium occurred	cify)
IVISION	ending F sath. or: After he funer	atlo	Natural 5 ☐ Pending (Month, Day Y 2 ☐ Accident investigation	ear)		? ′es 2 □ No		,	
	or Attering	ertification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury building, etc. (		arm, street, factory, office	28	If. Location (Stre City or Town,	et and Number or Ru State)	ural Route Number,
_	spitel	O	29a. Certifier Certifying Physician: To the best of r	my knowledg	e, death occurred at the time	e, date and place, an	d due to the cau	se(s) and manner as	stated
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	ledical	one and manner state	kamination ar	nd/or investigation, in my op	inion, death occurred	at the time, date	and place, and due	to the cause(s)
	To vitt	Σ	29b. Signatureland title of certifier	111	29c. License	59UI	290	Date signed (Monti	, Day, Year)
	:4		30. Name and address of person who completed cause of deal	th (Item 23a)	(Type, Print)	J   1			
	10		DR. SYlvia MORRIS 9000 F.	RANK	TIN SQUADE	= DR. B.	AlTimo	DE Mai	21/237
	Sta Registr		31. Date filed (Month, Day, Year)  DEC 1 0 2004  33. Registrar's	Signature	Sparker .				

LAWRENCE

			1 - For State Registrar	State	of Marylar	-	artment o <i>rtificate d</i>			Mental Hy	/giene Reg. No.	100%	39146
	Dhysia		1. Decedent's Name (First, Mid	ddle, Last)						2. Date of Do	eath Day	Year	3. Time of Death
	Physic /Medi		Erma D.	Lefever						Decemb	er 8		12:05 AM
2	Exami		4a. Facility Name (If not institu	•	number)		4b. City, Tow	n, or Location	n of Death		4c.	County of Deat	h
			Gilchrist Cer				Towso				Ba	altimor	
	Funeral Director		5. Social Security Number 159–54–6814	6. Sex 1 ☐ M 2 💆 F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Ye Months Da		ler 24 Hrs. Min.	8. Date of Bi (Month, D July 2	ay, Year)	9. Birt Co	hplace (State or Foreigi untry) PA
	and		Usual Residence of Decedent 10a. State 10b. Cour	nty	10c. Ci	ty, Town or Lo	ocation						10d. Inside City Limits
	f sh	5	MD D-3	timore		_1							1 ☐ Yes 2 🖔 No
	the 288	rec	MD Bal*  10e. Street and Number	rillore	<u> </u>	ckeysv	10f. Zip Cod	ie			10a Citi:	zen of What Co	untry?
	3a or		1 Warren Lodg	e Court 2	R		21030				U.S		,
	ms 2	Funeral Director	11. Marital Status	12. Was De	ecedent Ever in U		Was Decedent	of Hispanic (	Origin? (Sp	pecify Yes or No		4. Race - Ame	rican Indian,
21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or itams 23a or 28a-1 show or other traumatic event, the Medical Ever's arminal be tradified at		1 ☐ Never Married 2 ☐ M 3 ☑ Widowed 4 ☐ Divord	arried 1 Tye	Forces? s 2 <b>X</b> No Give Dates:	i	If Yes, specify 0 1 ☐ Yes 2 ☐ X			Rican, etc.)		Black, White Specify:	e, etc. White
Ö	72 ho	ted	15. Deced	lent's Education	الد	16a. Dece	dent's Usual Oc	cupation			16b. Kir	nd of Business/	Industry
2	within 7 ene. than "r	Completed by	Elementary/Secondary (0-12	hest grade complete  College	(1-4or 5+)	life.	kind of work do DO NOT use re	ne auring m itired)	ost of work	ring			
7	filed withi Hygiene. other than	Son	12			Home	maker				(	Jwn Home	3
pu	be file tal Hy d oth	Be (	17. Father's Name (First, Midd							e (First, Middle	, Maiden .	Sumame)	
yla	should be od Mental stranked o	ပို		ample						Krantz			
Maryland	1 and 2 sho Health and I tem 27 is me		19a. Informant's Name/Relation Nancy Lefever							al Route Numb 2B, Coc			<sup>(ip Code)</sup> MD. 21030
Baltimore,	permit. Pages 1 and Department of Healinportant: if item 2 any injury or othar once.		20a. Method of Disposition			Place of Dispo	sition (Name or natory or other	f place)		Date	, 20c. Loc	ation - City or	Town, State
Ĕ	Pages nent of I int: if its ury or o		1 XBurial 2 ☐ Cremation 3 ☐ Other		in State		dence M			/13/200 em.	4 Pr	roviden	ce Twp., PA
a	permit. Departmitimporta any inju		21. Signature of Funeral Servi	Licensee			. Name and Ad			Ruck To	Hean	Funenci	l Home, Inc
m	Depar Impol any ir	Ç., 1	Mulide	3.	Coster	1	NSO Vor	v Rose		wson, M			1204
Н			23a. Part1. Enter the disease, shock, or heart failure. L	or complications tha	t caused the deat	h. Do not ent	er the mode of	dying, such	as cardiac	or respiratory a	rrest,	41 TO	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Ch	Annie M	Colore	Aire	12/11.2	400	· duec			Onset and Death
	/Medical		resulting in death)	aDue t	o (or as a conseq	juence of):	TOT P	Olowo	riory	Ju to	4		years
П	Examiner					,							
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due I	u (ul as a CONs <del>0</del> 0	uence of).							
	eath certificate be executed attending physician and for use as the burial-transit	Examiner	that initiated events	С.									
Ö,	e exe	EX	resulting in death) Last	Due t	o (or as a conseq	uence of):							
68760,	ate b hysic he bi	edical		d.									
39	ng pt		IF FEMALE:										
Вох	ath ce itendi	an/i	23b. Was decedent pregnant in the past 12 months?	23c. If yes, o	outcome of pregna	ancy iIdeath 3□	Ectopic pregna	псу			2	3d. Date of deliv	,
E	the at	Physiclan/M	1 ☐ Yes 25 No 9 ☐ Unknown		gnant at time of d		Other (specify	)				Month	Day Year
0	that the di led by the detached	Phy		ini and a second state of the second	ale alt I a cal	to:				an Biri			
Ś	ires that signed b	by	Part II. Other significant cond	eart ball	7	ulting in the ui	nderlying cause	given in Par	t I.				the cause of death?
oro	w requir been si should	ted	Corgestion V	earl John	<i>10</i> 416					1	Yes 2	lNo 3□Pro	bably 4 Unknown
ec	e law has b	Completed								24a. Was auto	osy	24b. Were aut	opsy findings available empletion of cause of
<u> </u>	The	Co								perfo	rmed? 2.S.No	death?	2 □ No
Vital Records,	ysician: The is certilicate hadirector, page	Be	25. Was case referred to medi examiner?						ce of Deat	h (Check only d	one)		
<del>o</del>	Physi this c	P	1 □ Yes 2 XNo			ER/Outpatien	1 3 DOA		Nursing Ho	me 5 🗆 Resi	dence 6	Other (Spec	IN HOSPICI
Ē	ding P h. After 1 tuners	on:	27. Manner of Death  1 X Natural 5 Pen		e of Injury onth, Day Year)	28b. Time of Injury		njury at Vork?		28d. Describe l	how injury	occurred	•
<u> </u>	uttendi death. ctor: A y the tu	cati		stigation			M 1	☐Yes 2[	□ No				
Division	or At fter d lirect n by	Certification:	4 Homicide dete	mined 200. Pla	ce of Injury - At ho Iding, etc. (Specif	ome, farm, str	eet, factory, office	СӨ		28f. Location (S City or Tox		Number or Rui	al Route Number,
	urs a urs a ral D												
	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death.  Within 24 hours after death.  Within 24 hours after death.  Sompletely filled in by the tuneral director, page 2 should be detached for use a.	Medical	29a. Certifier 1 Certification (Check only one) 1 Medic	ying Physician: To t al Examiner: On the and ma	he best of my kno basis of examina anner stated.	wledge, death tion and/or inv	occurred at the restigation, in m	e time, date a ly opinion, de	and place, eath occurr	and due to the red at the time,	cause(s) a date and p	ind manner as s place, and due t	stated. to the cause(s)
	ompl	Me	29b. Signature and title of certi				29c. Lice	edmun eane	r		29d. Date	signed (Month,	Day, Year)
	0		MAKA	are	MA		D	583	203			nbee 8	
1	N)		30. Na a ca ress of perso	on who completed on	use of death (Item	n_23a) (Type,		/				*174	
7	{'		January of Person	CHARLU	ES, W	D (Type,	11111/						s Street
	Sta	te	31. Date filed (Month, Day, Yea	ar) 32.	Registrar's Signa	iture				Tow	son,	Md, . 2	1204
	Registr		20040			39	13						

DHMH 17 Rev 1/2001

12:05 AM

LEFEVER, ERMA

ORIGINAL

			1 - For State Registrar	State of M	laryland /		irtment of			F	Reg. No:	11111	39147
	Physici	an	Decedent's Name (First, Middle	,						2. Date of Dea Month	Day		3. Time of Death
	/Medio Examir		Della Ruth  4a. Facility Name (If not institution,		)		4b. City, Town	n, or Location		Dec.	0 4 4c.	2004 County of Deal	
	LAGIIII		Howard County			tal	Colur					oward	
	Funeral			6. Sex 7. A 1 ☐ M 2 X F	ge (In yrs. last b	**	If Under 1 Ye Months Da		ler 24 Hrs. s Min.	8. Date of Birth (Month, Day			hplace (State or Foreign
	Director		310-05-0175 Usual Residence of Decedent	10 11 221	88	Yrs.						1916 Tenr	
	yland		10a. State 10b. County		10c. City, To	wn or Loc	cation						10d. Inside City Limits
	e Ma	Director	MD Howard	i 	Colum	nbia							1 ☐ Yes 🎢 No
	with the	Dire	10e. Street and Number				10f. Zip Cod	е			10g. Citi	zen of What Co	ountry?
	leath	Funeral	5533 Coltsfoo	ot Court 12. Was Deceden	Fver in U.S.	13 V	2104		Origin? (Sp.	acify Vas or No-	!	USA 14. Race - Ame	nican Indian
9	or iten		1 Never Married 2 Marrie	Armed Forces	?	1				ecify Yes or No- Rican, etc.)		Black, White	e, etc.
003	n 72 hours after death with the Maryland "neturel", or items 23a or 28a-1 show salcal Examinar must be notified at	d by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates		1	□Yes 2X11	No Speci	ify:			Specify: Wh	ite
21215-0036		Completed	15. Decedent' (Specify only highest	s Education t grade completed)	16	(Give F	ent's Usual Ockind of work do. NOT use rei	ne during m	ost of work	ing	16b. Kir	nd of Business/	Industry
17	filed within Hygiene. Other than "	omp	Elementary/Secondary (0-12)	College (1-4or				irea)			0.	ın II.	
br	₽ <del>1</del>	Be C	17. Father's Name (First, Middle, L	ast)		ишеш	aker	18. Mo	ther's Name	e (First, Middle,		VN HOM Sumame)	e
Maryland	should be and Mental marked o	To E	James Isaac	Smith				Ros	e Eti	ta Smit	:h		
Nar			19a. Informant's Name/Relationsh	ip (Турв, Print)						al Route Number			
	s 1 and 2 of Health a Item 27 is other tree		Laurice McAfe 20a. Method of Disposition	e	5 5 20b, Place	of Dispos	Coltsf	oot	Court	Colu	idmi	a MD	21045
nor			1 ☐ Burial 2 MCremation  4 ☐ Donation 5 ☐ Other (Sp		, ,		sition (Name of atory or other p	1					
Baltimore,	그 본 원 등		21. Signature of Funeral Service L		рисшо	22.	Name and Ad	dress of Fac	Cility N7 i t	7/20041	aur	rel, Ma	aryland mes, Inc.
m	permi Depa Impo eny ir		Thinke /4	1		5.	555 Tw	in K	nolls	Road.	Cc	aı no. Olumbia	mes, Inc. a. MD 21045
П			23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that cause only one cause on each	d the death. Do	not ente	r the mode of o	tying, such a	as cardiac o	or respiratory arr	est,		Approximate Interval Between
	Priysician	61	Immediate Cause (Fina) disease or condition resulting in death)	_a	LOCAFO	dial	Inf	arcti	ion				Onset and Death  10 hours
В	/Medical Examiner		resoning in deathy	Due to (or as	a consequence  SCENdi  a consequence	e of):							
	त्र <sup>े</sup>	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence	ng i	aortic	an	eur	ysm			1/2 years
	cuted nd ransit	Examine	that initiated events		Per								1/2 years
, 0,	cate be executed obysician and the burial-transit	I Ex	resulting in death) Last	Due to (or as	consequence	e of):							
8760,	physic physic the b	edlcal		d									
Box 6	death certificate e attending physic for use as the	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy						2	3d. Date of deli	von.
	death e atter	Physician/M	in the past 12 months?	4☐Pregnant a	2 ☐ Fetal deat t time of death		Ectopic pregnal Other (specify)				-	Month	Day Year
P.O.	t the by th ache	hys	9 Unknown	9∐Unknown									
	res tha igned I be det	by F	Part II. Other significant condition	s contributing to death I	out not resulting	in the un	derlying cause	given in Par	t I.				the cause of death?
orc	law requires as been sign 2 should be	eted								1 L Ye	es 2U	rNo 3∐Pro	obably 4 Unknown
Division of Vital Records,	0 4 0	Completed					·····			24a. Was a autops perforr	v	24b. Were aut prior to c death?	topsy findings available ompletion of cause of
[a]	00 14	မ လ	25. Was case referred to medical							1 ☐ Yes 2	2 <b>□</b> 1√0	1 ☐ Yes	2 No
>	tending Physicien: leath. tor: After this certifici the funeral director, i	To B	examiner?	Hospital:	ent 2 ER/O	Outpatient	3□ DOA	Oth an		(Check only on ne 5 ☐ Reside	,	□Other /Spec	ify)
0 1			27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	ury 28b.	Time of Injury	28c. In		_	28d. Describe ho			,,
Sio	Attending r death. ector: After by the fune	catle	2 Accident investigated as Suicide 6 Could no	ation N/	A		M 1	□Yes 2[	-				
ĭZ	or At fter o yirec in by	Certification:	4 Homicide determin	ned 286. Place of in	jury - At home, f tc. <i>(Specify)</i>	farm, stre	et, factory, offic	<b>(a</b>	2	28f. Location (St. City or Town	reet and , State)	Number or Ru	ral Route Number,
	spitel ours neral filled		29a. Certifier 1 Certifying	Physicien: To the best	of my knowledg	e. death	occurred at the	time date a	and place a	and due to the ca	use(s) :	and manner as	etated
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	edical	(Check only 2 Medical E	xaminer: On the basis of and manner st	if examination a	nd/or inve	estigation, in m	y opinion, de	eath occurre	ed at the time, da	ate and	place, and due	to the cause(s)
	To the Hospitel within 24 hours a To the Funeral C completely filled	M	29b. Signature and title of certifier	00.	•			nse numbe		25	9d. Date	signed (Month	. Day, Year)
	-10	1	> Symux	J. Ollen	so n	5.1		3248			DE	C/06	0/2004
	0		30. Name and address of person w		leath (Item 23a) E Gui		rint)	C.		ora, Ma	. ~		
	Sta	te	31. Date filed (Month Day, Year)	-	rar's Signature	101	a Kd	(0)	umb	o.a. Ma	( , ,)	1046	
	Registr		DEC 1 0	2004		B	for	Cs!					

			For State Registrar	State of Ma	ryland / Depa	artment of F	lealth and N	/lental Hy	gienez 0	04	39148
	Physic /Medi		Decedent's Name (First, Middle, Last,     MC	LLIE		LEV	IN	2. Date of De	BER <sup>Day</sup> , 20	) <del>(</del>	3. Time of Death 4:45 A M
	Examir		4a. Facility Name (If not institution, give MILFORD MANOR NUF	-		4b. City, Town, o BALTI	r Location of Death		4c. County BALT		
	Funeral Director		0, 0, 10	7. Age	(In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da OCT.7,	1915	9. Birthp Coun	place (State or Foreign htry) MD
	Maryland f show led al	tor	Usual Residence of Decedent  10a. State 10b. County  MD BA	LTIMORE	10c. City, Town or Lo	cation	RANDALLS	TOWN		1	Od. Inside City Limits 1 ☐ Yes 2 🙀 No
	th with the 23a or 28a ist be notifi	ai Director	10e. Street and Number 3918 ZURICH ROAD			10f. Zip Code	21133	TOWN	10g. Citizen of W	hat Coun	
9036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If itam 27 is marked other than "natural", or itams 23a or 28a-f show or other traumatic evant, the Medical Examinar night or notified at	d by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 🏋 Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	o It	Vas Decedent of Hi Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Race Blac Specify	k, White,	ean Indian, etc. WHITE
Maryland 21215-0036	id within 72 h giene. er than "natu	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12		(Give	ent's Usual Occup kind of work done of OO NOT use retired W TEACHER	during most of work 1)	ing	16b. Kind of Bu		lustry
ryland	should be file ind Mental Hy is markad oth umatic evant	To Be (	17. Father's Name (First, Middle, Last)  JOSEPH  19a. Informant's Name/Relationship (Ty	ina Print)	LEVIN	Address (Sansa	18. Mother's Name				GLASSER
re, Ma	s 1 and 2 s Health an Itam 27 is r other traur		MICHAEL LEVIN / S 20a. Method of Disposition	ON		STONEBRO	OOK LANE	- COLUM		21046	6
	permit. Pages Department of I Important: If its any injury or o		1 X Burial 2 Cremation 3 PR 4 Donation 5 Other (Specify) 21. Signature of Juneral Service License		HEBREW OR	THODOX ME Name and Addres	MORIAL 1: Ses of Facility SO TERSTOWN	2/09/20 L LEVIN	04 DUN ISON & BR	DALK	, MD INC.
	Pnysician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	BEM	he death. Do not ente						Approximate Interval Between Onset and Death
	physician and physician and sthe burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):	Diseas	e				8415
P.O. Box 6	t the death certif by the attending ached for use as	Completed by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	3c. If yes, outcome of 1□Live birth 2 4□Pregnant at ti 9□Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Mon		ry Day Year
ords, P	w requires tha s been signed I should be det	ted by P	Part II. Other significant conditions con	tributing to death but	not resulting in the un	derlying cause give	en in Part I.		obacco use contri		e cause of death?
al Rec	ysician: The law r is certificate has be director, page 2 sh		05 W.					24a. Was autop perfor 1 Yes	rmed? pr	for to comeath?	sy findings available inpletion of cause of
Division of Vital Records,	<b>€</b> = <u>F</u> =	tion: To Be	25. Was case referred to medical examiner?  1  Yes 2 No H  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 28a. Date of Injury (Month, Day)	t 2 ER/Outpatient 28b. Time of Injury	28c. Injury Work	26. Place of Death  PT: 4 Nursing Hor  at  ??  Yes 2 □ No	me 5 Resid			1
Divis	To tha Hospital or Attanding within 24 hours after death. To tha Funaral Diractor: After completely filled in by the funer	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injur- building, etc.	y - At home, farm, stre (Specify)	et, factory, office		28f. Location (S City or Tow	Street and Number on, State)	r or Rural	Route Number,
	To tha Hospital or A within 24 hours after To tha Funaral Dira completely filled in by	Medical	one)	icien: To the best of ler: On the basis of e and manner state	my knowledge, death examination and/or invested.	estigation, in my op	pinion, death occurre	ed at the time, o	date and place, ar	nd due to t	the cause(s)
1	To To COr	-	29b. Signature and title of certifier	m		29c. License		-	12\8(00		ay, Year)
	Ç, Sta	te	30. Name and address of persor who co 200 ext M. Coot 31. Date filed (Month, Day, Year)		6503		HEIGHTS	AVE	BACT	MD	21215
DHM	Registr	ar	DEC 1 0 2004			Soul.	•				
					ORIGINA	L					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 8 per th 3845 7-18-05 vt.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Menth LOPES 5:00 A M **EDWARD** /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7876 Golden Pine Circle Anne Arundel Severn 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Guntry)
 Mass. **Funeral** Months Hours Days 017/01/8703 1√2M 2□ F 90 Yrs Director 7-4-1914 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and If item 27 is marked other than "naturel", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23a or 28a-f show other traumatic event, its Mudical Examinar must be notified at MD AA Severn 1 Yes ZNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21144 7876 Golden Pine Circle USA by Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bfack, White, etc. 11. Marital Status 1 Never Married 2 Married XX Yes 2 No Specify Portuguese Baltimore, Maryland 21215-0036 white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) self emp. retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Julio Lopes Mary Desanges 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michele Peterson (daughter) 7876 Golden Pine Circle, Severn, MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ō 1 Burial 2 Cremation 3 Removal from State Department of Importent: If any injury or once. '4 □Donation 5 □Other (Speqith tombment Meadowridge Mem. Pk. 12/9/04 Elkridge, MD 21. Signal re of Fundamental Service Ligansee 22. Name and Address of Facility Singleton Funeral Home 1 Second Ave SW Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervaf Between Onset and Death fmmediate Cause (Final **Physician** neum disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a Examiner 2 ed by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown tor; After this certificate has been signed by the funeral director, page 2 should be detact Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 nonagenariar 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2□ No 1 Yes Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only or examiner? Other: 4 Nursing Home 1 🗌 Yes 1 Inpatient 5 Residence 6 □Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 28c. fnjury at Work? . Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred Naturaf 2 Accident Injury 5 Pending efter death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours e e Funerel [ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier (Check only one) Medi within 2 To the 2 Highway #204 millersville MO of death (Item 23a) (Type, Print) Name and address of person who completed cause conMO 8601 elsecca 31. Date filed (Month, Day, Year)
DEC 1 0 2004 State

DHMH 17 Rev 1/2001

Registrar

	_	Tor State Registrar	State of Maryland / (	Depar <i>Certi</i>	tment of He	alth and Me eath	ental Hygiene Reg. No		39150
	\$.	Decedent's Name (First, Middle, Last)				1	2. Date of Death Month Da	ıy Year	3. Time of Death
Physici /Medic		Vivian W.	Logan				ecember	4 2004	5:53 p <sup>M</sup>
Examin	er	4a. Facility Name (If not institution, give st	reet and number)	1	lb. City, Town, or Lo		40	. County of Death	
Funeral Director		Knollwood Manor 5. Social Security Number Manor	Nursing Center 85	Yrs.		f Under 24 Hrs. 8 Hours Min.	<ol> <li>Date of Birth (Month, Day, Year,</li> </ol>	ne Arur 9. Birthr Coul 915 New	lace (State or Foreign htry)
pu 3		Usual Residence of Decedent  10a. State 10b. County	10c. City, Tow	wn or Loca	tion			1	0d. Inside City Limits
Aaryta   sho	0	,							1 ∰Yes 2 ☐ No
.0036 hours after death with the Maryland turel', or tteme 23e or 28e-1 show at Exeminer must be notified at	Directo	Maryland Anne Ar		2011	10f. Zip Code		10g. Ci	itizen of What Cour	ntry?
death	Funeral	631 Admiral Dri	2. Was Decedent Ever in U.S.	13. Wa	21401 as Decedent of Hisp	anic Origin? (Spec	rfy Yes or No-	14. Rece - Amend	an Indian,
1215-0036 ithin 72 hours after one. hen "natural", or itee	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1		Yes 2 PNo	Specify:	ican, etc.)	Black, White,	
5-00;	Completed	15. Decedent's Educ (Specify only highest grade		(Give ki	nt's Usual Occupation of work done dur			(ind of Business/In	dustry
	Idm	Elementary/Secondary (0·12)	College (1-4or 5+)		NOT use retired)				
filed v Hygie ont.		12th 17. Father's Name (First, Middle, Last)	0	_Se	cretary	8. Mother's Name (	Fed First, Middle, Maide		vernment
d be id  To Be	Unobtainab	10			Maude	Greene			
ire, Maryland Z. s. 1 and 2 should be filed v if Health and Mental Hygie item 27 is marked other to	-	19a. Informant's Name/Relationship (Typ		b. Mailing	Address (Street and		Route Number, City	or Town, State, Zip	Code)
		Sandra I. Frankl 20a. Method of Disposition	in (Cousin)	100	Ramano	Trail H	1 Allent	own. Pa	. 18104
U 00		20a. Method of Disposition 1 ☐ Burial 2% Cremation 3 ☐ Re	cemete	of Disposit ery, crema	ion (Name of tory or other place)	Da	te 20c. L	ocation - City or To	own, State
altimore, mil. Pages 1 ar partment of Hea portant: if item y injury or othe		* 4 □ Donation 5 □ Other (Specify)	Metro		ematory		2/04 Ba	ltimore	, Md.
Baltim permit. Pag Department important: I any injury o		21. Signature of Funeral Service Licenses  Lavry H. Reas  23a. Part 1. Enter the disease, of complice			Name and Address  N. Reese  21 West		Mortuar	y, P.A. Md. 214	Approximate Interval Between
J1		snock, or near failure. List only one	cause on each line.						Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	CARDIO VA	·	ILAK I	SISEASE			YEARS
Examiner		Seamentianty her constitues							
/B = 5	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	of):					
8760, cate be executed physician and the burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequence	of):				-	
8760 ate be e hysician the buria	dicai E	d							
68 tiflicate g phy as the	ledic								
O. Box 61 he death certific the attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	c. If yes, outcome of pregnancy 1 \( \subseteq \text{Live birth} \) 2 \( \subseteq \text{Fetal death} \) 4 \( \subseteq \text{Pregnant at time of death} \) 9 \( \subseteq \text{Unknown} \)		ctopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
IS, P.O.	by Ph	Part II. Other significant conditions conf	ributing to death but not resulting	in the und	erlying cause given	in Part I.	23e. Did tobacco	use contribute to t	ne cause of death?
rds quires in sign	q pa						1 🗌 Yes 2	No 3 Prot	ably 4 Unknown
Division of Vital Records, P.O or Attending Physician: The law requires that the after death. Director: After this certificate has been signed by the funeral director, page 2 should be detach.	Completed						24a. Was an autopsy performed?	prior to co	psy findings available mpletion of cause of
Vital F iician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?			2	6. Place of Death			
of V Physic this ce al direc	To	1 ☐ Yes 2 No	ospital: 1 Inpatient 2 ER/O	Outpatient	3 DOA Other:	4 Nursing Hom	e 5 🗆 Residence	6 ☐ Other (Specif	y)
Vision of Vital Attending Physician: r death. ector: After this cartifici by the funeral director, i		27. Manner of Death  1 Anatural 5 Pending 2 Accident Investigation		Time of Injury	28c. Injury a Work? M 1 ☐ Ye	s 2 □ No	3d. Describe how inju	ury occurred	
Division of Vital References to the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate the completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, for building, etc. (Specify)	farm, stree	t, factory, office	20	af. Location (Street a City or Town, Stat		I Route Number,
Div To the Hospital or A withn 24 hours after To the Funeral Dire completely filled in b	Medical C		icien: To the best of my knowledg er: On the basis of examination a and manner stated.	ind/or inve	stigation in my opin	nion, death occurred	d at the time, date an	id place, and due to	the cause(s)
To the within To the complete	Me	29b. Signature in title of certifier	1 1.		29c. License r	number	29d. Da	ate signed (Month,	Day, Year)
		10m (-u	allace m	2)	D31	136	DEC	EMBER	9,2004
3		30. Name and address of person who con		900) (Type, P	int) KILB	BRIDE R	OAD, BALTI	MORE M	Day, Year) 9, 2004 9 21236
Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	1.	1		,	7	
Regist	ar	DEC 1 0 20	04 Geneva	B	Spork	2			

			1 _ State	partment of Health and Mertificate of Death	-	_ / II II lu	39151
			Registrar  1. Decedent's Name (First, Middle, Last)	Crimeate of Death	Reg.	No.	3. Time of Death
	Physici	an	Mildred Viven McGuire		Month	Day Year	
	/Medic		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		3 2004 4c. County of Death	10:30A <sup>M</sup>
	Examin	er	1102 Wild Orchid Dr.	Fallston		Harford	
-	Funeral	-	5. Social Security Number 6. Sex 7. Age (In yrs. last birthd.	ay) If Under 1 Year If Under 24 Hrs.	8. Date of Birth		place (State or Foreign intry)
	Director		213-03-6963 1 M 20 F 85 Yrs	Months Days Hours Min.	9-10-1		rvland
	D C		Usual Residence of Decedent				
	show	_	10a. State 10b. County 10c. City, Town or				10d. Inside City Limits
	Ba-f s	cto	MD Harford Fallst				1 ☐ Yes 2√∏ No
	death with the Maryland rms 23a or 28a-f show ir rust be notified at	Director	100. Street and Number 1102 Wild Orchid Drive	10f. Zip Code 21047	-	Citizen of What Cou	untry?
	s 23s	ra				14. Race - Amer	in a tasking
	er de Item	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	<ol> <li>Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto</li> </ol>	Rican, etc.)	Black, White	
20	irs aft	by	3 ☑ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 🔀 No Specify:		Specify: Wh	ite
2-003e	be filed within 72 hours after death with the Marylan ital Hygiene. Ind other than "naturel", or items 23a or 28a-1 show event, the Medical Examiner must be notified.		15. Decedent's Education 16a. De	cedent's Usual Occupation	16b	. Kind of Business/l	ndustry
<u>.</u>	n n	plet	(Specify only highest grade completed) (G Elementary/Secondary (0-12) College (1-4or 5+)	ive kind of work done during most of worki e. DO NOT use retired)	ng		
7	d within giene. or than	Completed		ministration	S	state of	MD
ğ	be filed ttal Hygi od other event, I	Bec	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maid	den Sumame)	
yiana	should be nd Mental marked	To E	William Fauth	Kather	rine D	oughery	
Mar	2 sho and le ma	1 0		ailing Address (Street and Number or Rura			
e, S	rt tr			02 Wild Orchid D		ston, M	
	@ O L		14 Burial 2 Cremation 3 Removal from State	crematory or other place)	26	. Location - City or 1	
Ē	Pag iment tant: jury o	١.,	4 Donation 5 Other (Specify) Parkwo	odd cemetery	2004 Ba	ltimore	
бащтог	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral S. most censee	22. Name and Address of Facility Eva			
_	005 e d		M01220	8800 Harford Rd		rille, M	
			23a. Part Enter the disease or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)    Dementiq				
	/Medical Examiner		Due to (or as a consequence of):				
		_	Sequentially list conditions, if any leading to immediate b.  Due to (or as a consequence of):				
	ted	Examiner	cause. Enter Underlying Causa (Claease of Injury				
_6	al-tra	xar	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
9/PU	certificate be executed iding physicien and ise as the burial-transit	dlcal E	d				
200	ificate g phy as the	a	V				
XON ROD	eath certific attending p I for use as I	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death	3 DEctopic pregnancy		23d. Date of deliv	very
n	death le atter ad for u	icla		5 Other (specify)		Month	Day Year
л Э	at the by th tache	hys	9 ☐ Unknown				
	w requires that the deben signed by the should be detached	by F	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part f.		o use contribute to	
ğ	equir en si ould			<del></del>	1 🗆 Yes	2 (⊈No 3 (□ Pro	bably 4 Unknown
ecords	a a ca	Completed			24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of
<u> </u>	ate pag	Con			performed 1 ☐ Yes 2 ☑	No 1 Yes	2 No
VII	Physician: The la this certificate ha ral director, page 8	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)		
Ö	Physic this o	은	1 Yes 2 Hospital: 1 Inpatient 2 ER/Outpa		me 5 Residence		ify)
	th. After t	on:	27. Manner of Death 1 Manural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Tim Injur	y Work?	28d. Describe how in	njury occurred	
<u>S</u>	Attending r death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be 288 Place of Injury At home farm	M 1 Yes 2 No	28f. Location (Street	and Number of Pu	ral Paula Alumbas
UIVISION	2 # E C	Certification:	4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Replace of Injury - At home, farm, building, etc. (Specify)	street, factory, office	City or Town, St	ale)	ar noute Number,
_	spital or cours afte neral Dir filled in		29a. Certifier 1 Certifying Physician: To the best of my knowledge, d	eath occurred at the time, date and place a	and due to the cause	e(s) and manner as	stated
	Hos 24 ho Fun	Medical	iCheck only 2 Medical Examiner: On the basis of examination and/o one)	r investigation, in my opinion, death occurre	ed at the time, date	and place, and due	to the cause(s)
	To the Hospital within 24 hours a To the Funeral Completely filled in	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month	Day, Year)
	P S P O	P	Samuel ( (Juno mo)	D 004704	0 1	2/9/0	4
	F-710		30. Name and address of person who completed cause of death (Item 23a) (Ty	pe, Print) Hopkin Dayree		1 11	
ĺ	$\cup$		Samuel C. Durso MD 5505	Honkin Bayree	Circle	Baltimo	1XGGGAN ST
	Sta		31. Date filed (Month, Day, Year) \$2. Registrar's Signature	1.1.	- V		7
	Regist	rar	DFC 1 0 2004 Shows	pours			

			1 - For Stata Registrar	State of	Maryland / Dep <i>Ce</i>	artment of F	lealth and N Death		iene 0 0	4 3915	52
	Dharia		1. Decedent's Name (First, Midd	lie, Last)				2. Date of Deat	h	3. Time of D	eath
	Physic /Medi		Nellie	Mullins				Month Decembe		Year 004 2:30	ΑМ
	Exami		4a. Facility Name (If not institution	on, give street and numb	oer)	4b. Cily, Town, or	r Location of Death		4c. County of		
			Chesapeake	Hospice Hou	ıse		Linthicum	1	Anne	Arundel	
	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	Year)	9. Birthplace (State or F Country)	Foreign
	Director		219-20-7160	I I I Z LAIN	89 Yrs.			2/15/15	915	Virginia	
	land		Usual Residence of Decedent  10a. State 10b. County	/	10c. City, Town or Lo	ocation				10d. Inside City	Limite
	Marylan I show ied al	ō	MD Anne	Arundel	Clan	Burnie				1 ☐ Yes 2	
	28a	Director	10e. Street and Number	Arunger	Gren	10f. Zip Code		10	0g. Citizen of Wi	hat Country?	
	3a or	Ö	20 St. Agnes	Road		2106	0		U.S.A	,	
	ter death	Funerai	11. Marital Status	12. Was Decede	ent Ever in U.S. 13.	Was Decedent of H		ecify Yes or No-		- American Indian,	
36	E 0 a	by Fur	1 ☐ Never Married 2 ☐ Mar 3 ☑ ∰idowed 4 ☐ Divorced	If Yes Give	XX.	lf Yes, specify Cuba 1 □ Yes		Rican, etc.)	Black	, White, etc. White	
21215-0036	72 hours "natural",			nt's Education		dent's Usual Occupa	ation		16b. Kind of Bus	ino and adverted	
715	9 1 3	Completed		ist grade completed)	(Give	kind of work done of DO NOT use retired	during most of work	ing	IOD. KING OF BUS	ness/industry	
212		E	12	College (1-4	or 5+)	Homemak	er		Own H	ome	
B	be tiled traft Hygie of other avant, III	Ø.	17. Father's Name (First, Middle,	Last)			18. Mother's Name	e (First, Middle, M	faiden Sumame	)	
<u>lar</u>		To B	David Lee	Cantrell			Mary	geneva M	iullins		
Maryland	2 8 8 5	ľ	19a. Informant's Name/Relations	ship (Type, Print)	19b. Mailir	ng Address (Street a	and Number or Rura	al Route Number,	City or Town, S	tate, Zip Code)	
	1 and 2 Health tam 27 I		Ina Kelly - D	aughter	1613	3 Lorimer	Road, G1	en Burni	e, MD 2	1060	
ore			20a. Method of Disposition 1 XX urial 2 ☐ Cremation	2 Demousifron St	20b. Place of Dispo	sition (Name of natory or other place	e) [	Date 2	0c. Location - C	ity or Town, State	
Ĕ	Pages ment of I ant: If its ury or o		`4 □Doration 5 □ Other (S	Specify)	Glen Ha	ven Mem.	Pk. 12/7	/04	Glen Bu	rnie, MD	
Baltimore,	permit. Page Deportment Important: If any injury or once.		21. Signature of Funeral source	Licensee		. Name and Addres					
<u></u>	<u>v</u> 0 5 2 3		Kelly Grego							MD 21061	
			23a. Part1. Enter the disease, or shock, or heart failure. List	r complications that cau tonly one cause on eac	sed the death. Do not ent h line.	er the mode of dying	g, such as cardiac o	or respiratory arre	st,	Approximate Interval Between	
	Pnysician	6.0	Immediate Cause (Final disease or condition	a cere	brovascu	ear i	disea	ee.		Onset and Dea	ith
	/Medical Examiner		resulting in death)	Due to (or	as a consequence of):					7	
		<u></u>	Sequentially list conditions, if any leading to immediate	b. Aye	as a consequence of:	2				year	S
10	cuted nd ransit	nin	cause. Enter Underlying Cause (Disease or injury	Laura	10 = 10					J	
-1	axecu al-tra	Examiner	that initiated events resulting in death) Last	c. Dye to (or	as a consequence of):	muz				year	<u>ک</u>
8760,	cate be executed physician and the burial-transit	dicai I		d						•	
9	tificat g phy as th	edi									
Вох	death certific e attending p d for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor		Ectopic pregnancy			23d. Date	of delivery	
	0 0 2	sicia	in the past 12 months? 1 ☐ Yes 2 KNo		t at time of death 5	Other (specify)			Month	Day Year	r
0.0	res that the death igned by the atte be detached for	Phy	9 🗆 Unknown								
Ś	The law requires that the tee has been signed by thoage 2 should be detache	by	Part II. Other significant condition	ons contributing to death	h but not resulting in the ur	iderlying cause give	n in Part I.			ute to the cause of deati	h?
Record	w requir been si should	Completed	OSTEUPOVOS	13, 05/	200011	1 112, 0	mil	1 Tes	2 No 3	Probably 4 Unkr	nown
Sec	e law has b	npie	and chior	Tic pair	n Syndi	ome,	coronav	24a. Was an autopsy	Dric	re autopsy findings avai or to completion of cause	ilable e of
_		S	artery dis	eace, con	ngestive h	eart Fe	vilure 6	7 perform 1 □ Yes 2	ed? dea	uth? ]Yes 2□ No	
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	<del>U</del>	000	26. Place of Death	(Check only one,	)		-
	S S S	OI:	1 Yes 2 No 27. Manner of Death	1 □ Inpa			4 Li Nursing Hon	ne 5 Residen			ce
n O	ding Ph h. After thi tuneral	tion	1 Natural 5 ☐ Pendin	ig (Month, i	njury 28b. Time of Day Year) Injury	28c. Injury Work	at ? ′es 2 ⊡No	28d. Describe how	injury occurred	House	ع
Division of	I or Attandi atter death. Diractor: A in by the tu	fica	2 Accident investig	not be	Injury - At home, farm, stre			28f Location (Stre	et and Number	or Rural Route Number.	
<u>S</u>	To tha Hospital or Attanding within 24 hours after death. To tha Funaral Diractor: After completely tilled in by the tune.	Certification:	4  Homicide determ	building,	etc. (Specify)	out reactory, office		City or Town,	State)	or ribrar noble Number,	
	Hospital 24 hours a Funaral I stely tilled		Officer of the Particular	ig Physician: To the be Examiner: On the basis	st of my knowledge, death of examination and/or inv	occurred at the time	e, date and place, a	and due to the cau	ise(s) and mann	er as stated.	
	within 2 To tha complet	Medical	one)  29b. Signature and title of certifier	and manner	stated.						
ı	5 1 × 1		290. Signal e and title of certifier	119	2 2 2	29c. License	number	290	J. Date signed (A	Month, Day, Year)	
,						10	41435		12-0	0-04	
	6		30 Name and address of person	who completed cause o	f death (Item 23a) (Type, F	He sano	1-1.	My #3	04/000	21108	2
	Sta	te	31. Date filed (Month, Day, Year)	32. Regi	strar's Signature	1010(1)	1139 VM	1/11	www.	VILLE, MI	
	Registr	_	her 10	enta Sen	wa &	Looks		0			
			DEU - V		-						

	_	For State Registrar	State of Maryla		artment of H tificate of I			201	04 3915
Physiciar /Medica	1	Decedent's Name (First, Middle, Last	EDWARD G	. MALDE	IS		2. Date of Death Month		Year 3. Time of Death
Examine	r	4a. Facility Name (If not institution, give St. Agnes Hos	•			Location of Death		4c. County of	f Death
Funeral Director		213 00 0091	x 7. Age (In y. 52	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	1952	9. Birthplace (State or Foreig Country) Maryland
f show		Usual Residence of Decedent  10a. State 10b. County  Maryland Anne Ar		City, Town or Lo		Pasadena			10d. Inside City Limit
3a or 28a-f s at be notified	II Direct	10e. Street and Number 9 Wi	nding Woods	Way	10f. Zip Code	2112	2	. Citizen of Wh	nat Country?
natural, or items 23a or 28a-f show lited Examinar must be notified at	ny runera	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ত Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	11	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	14. Race	- American Indian, White, etc. White
it of Health and Mental Hygiene. If them 27 is marked other than "natural, or flems 23s or 28s-f show or other traumatic event, the Medical Examinar must be notified at To Re Commissed by Funeral Directors	Completed by	15. Decedent's Edu (Specify only highest grad	cation e completed)  College (1-4or 5+)	16a. Deced (Give life. E	ent's Usual Occupa kind of work done of OO NOT use retired, Supervis	luring most of work )	ing	b. Kind of Busi Constri Excava	uction &
Mental Hyg arked other atic event,	מ	17. Father's Name (First, Middle, Last)	Edward W. N	Maldeis	Buper vie	18. Mother's Nam	e (First, Middle, Ma M. Schafe	iden Sumame)	
27 is main r traums		19a. Informant's Name/Relationship (T) Patricia Maldeis	•				al Route Number, C napolis, l		tate, Zip Code) .401
a ti t		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)		Place of Dispose cometery, cremetery, cremetery	ition (Name of atory or other place ge Mem.	3) (-			ity or Town, State
Departn Imports any inju		21. Signature of Europa Service Licens	≫ Kevin E Ec	l <sup>v</sup> lC	Name and Addres Cully-Po 204 Mount	of Facility Lyniak Fu	ineral Hoi Pasadena	me, P.A	and 21122
as the burial-transit and transit and tran		23a. Part1. Enter the disease, or complishock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate Cause. Enter User ying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consider to co	equence of):					Approximate Interval Batween Onset and Death  WEEK
ed by the attending physicii detached for use as the bu		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	ital death 3 □	Ectopic pregnancy Other (specify)			23d. Date of Month	
be d	2	Part II. Other significant conditions cor	stributing to death but not re	esulting in the un	derlying cause give	n in Part I.		co use contribu	ute to the cause of death?
certificate has been s rector, page 2 should							24a. Was an autopsy performed	l? prio	re autopsy findings available or to completion of cause of th? Yes 2 \( \square\) No
	1	25. Was case referred to medical examiner?  1 □ Yes 2 No	ospital:	7500	Other	26. Place of Death		191	
ath. r: After this le funeral di	-	27. Manner of Death  Natural 5 Pending  2 Accident investigation	28a. Dat of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injury Work' M 1 \( \text{Y}		ne 5 Residence 28d. Describe how i		(Specify)
24 hours after death. Funeral Director: After tely filled in by the funeral lical Certification:		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre	et, factory, office		28f. Location (Stree City or Town, S	t and Number o tate)	or Rural Route Number,
e e e e		29a. Certifier Certifying Physics (Check only one) 2 (I) Medical Exemiser	sician: To the best of my kiner: On the basis of examinand manner stated.	nowledge, death nation and/or inve	occurred at the time estigation, in my opi	e, date and place, a nion, death occurre	and due to the cause ed at the time, date	e(s) and manne and place, and	er as stated. I due to the cause(s)
To t	1	29b. Signature and title of certifier	_		29c. License				Month, Day, Year)
12	3	30. Name and address of person who co	mpleted cause of death (Ite	em 23a) (Type, P	rint)	JOINTO	10 THE - 2	- 10-	754 4, 200
State Registrar	20	HOMAS J. ENE 31. Date filed (Month, Day, Year)	32. Hegistrar's Sign	900 c	CATON	AUE BA	NCTIMORE	, mo	\$1229

DHMH 17 Rev 1/2001

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Marylan	
Baltimore,	
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P.O. Box 68760,	the state of the s

			Please *	Гуре or Prin	t in Black In	idelible Inl	k. Ensure Al	l Copies	Are Legible.			
			1 - For State Registrar	State of Ma			Health and M	lental Hy	giene			
			1. Decedent's Name (First, Middle, Last	) 1	Ce	rtificate of	Death	2. Date of Dea	Reg. No	39154		
	Physici /Medio		Cocilia	C Mol	a			Decem.	ber 3 200	4 1:25 PM		
	Examir		4a. Facility Name (If not institution, give	street and number)		C >	or Location of Death		4c. County of Dea			
	Funeral		5. Social Security Number 6. Se	x Heigh to	(In yrs. last birthday	If Under 1 Yea	Burnie r If Under 24 Hrs.	8. Date of Birt	Hone 1	thplace (State or Foreign		
	Director		213-23-7070	☐ M 2 🗹 F	62 Yrs.	Months Days	s Hours Min.	8. Date of Birt (Month, Day 12/02/	1942 Ph	ilippines		
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Le	ocation	·			10d. Inside City Limits		
	Mary B-f sh	tor	MD Anne Arui	nde1	Glen Burn:	ie				1 ☐ Yes 2 🛣 No		
	or 28	<b>Funeral Director</b>	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	ountry?		
	eath v	eral	7535 Old Stage Roa	ad 12. Was Decedent Ev	ver in IIS 12	21061	Historia Osisin 2 (Cas	aife Van an Na	USA			
5-0036	ours after d ral', or iten	þ	1 X Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	,	If Yes, specify Cu	Hispanic Origin? (Speban, Mexican, Puerto Specify:	Rican, etc.)	14. Race - Ame Black, Whit Specify: As	e, etc.		
2	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23e or 28e-f show other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 12		(Give	dent's Usual Occu kind of work done DO NOT use retire	upation e during most of worki ed)	ng	16b. Kind of Business Food Servi	,		
Maryland 21	rould be filed with Mental Hygiene charked other the natic event, Its	To Be C	17. Father's Name (First, Middle, Last) Pedro M. Mola				18. Mother's Name		,			
ary	2 should and Meni is marka	ř	19a. Informant's Name/Relationship (T)	rpe, Print)			at and Number or Rura	l Route Numbe	r, City or Town, State, I	Zip Code)		
	1 and 1 Health em 27 ther tra		Mrs. Catalina Orda	ansa / Sis			ge Road Glo					
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other troops.		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Paration 5 ☐ Other (2) and (3)	Removal from State	-	matory or other pla	ace)	ate	20c. Location - City or			
alt III	permit. Page Department o Important: If any injury or once.		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service Licens</li> </ul>	one baptante of onation 12, 03, 200 T Be								
ñ	permit. Departr Importa any inji		Muchille Ca	ney mo	en Burn:							
Ī	Physician /Medical		23a. Part1. Enter the disease, or compishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. I Mac	he death. Do not ent.	0 1	ning, such as cardiac o	r respiratory and	rest,	Approximate Interval Between Onset and Death		
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of):					,		
'n	executed an and rial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):							
98/60	icate be physici s the bu	dlcal		d								
C. BOX	requires that the death certificate be exe een signed by the atlending physician al nould be detached for use as the burial-I	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 1 ☑ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal death 3	Ectopic pregn <i>a</i> nd Other (specify)	еу 		23d. Date of del Month	ivery Day Year		
S,	res that the de signed by the a I be detached (	by	Part II. Other significant conditions con	ntributing to death but	not resulting in the u	nderlying cause gr	ven in Part I.	23e. Did to	bacco use contribute to	the cause of death?		
Hecords	w require been sig should b	eted	Largeornyop	Hruj.	renasia	71, C	BREMST	1 🗆 Yı	es 2□No 3□Pr	obably 4 Unknown		
итаі жес	The larate has	e Completed	CONCON TREA	na ins	N Spicio	ncy			prior to death?  200 No 1 Yes	topsy findings available completion of cause of 2 No		
		0	25. Was case referred to medical examiner?  1 \( \text{Yes} \) 2 \( \text{\$\sqrt{1}\$} \) No	lospital:	2 ER/Outpatien	nt 3□ DOA Ot	26. Place of Death		ence 6 Other (Spec	ilin Sife (		
П OI	ding Physical After this funeral d	T :uo	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day )	28b. Time of	28c. Inju			ow injury occurred	any)		
JIVISION	Attanding or death. actor: After by the fune	catl	2 Accident investigation 3 Suicide 6 Could not be			M 1	Yes 2 □ No					
2	at or Ai s after ( il Dirac	Certification;	4 Homicide determined	building, etc.	<ul> <li>At home, farm, str (Specify)</li> </ul>	eet, factory, office	2	8t. Location (St City or Town	treet and Number or Ru n, State)	ral Route Number,		
	To the Hospital or Attanding Phwithin 24 hours after death. To the Funeral Diractor: After th completely filled in by the funeral	Medical (	29a. Certifier (Check only one) 1 Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifier (Check only one)	sician: To the best of ner: On the basis of earl and manner state	xamination and/or inv	n occurred at the tivestigation, in my	ime, date and place, a opinion, death occurre	nd due to the ca d at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)		
	To t To t	Σ	29b. Signature and title of certifier			29c. Licen	se number	2	9d. Date signed (Month	), Day, Year)		
	2	-	20 Name and address of	molecular and a district of the second of th	th (ltam 00 -) (T	1)(0)	52144	1	ecember	4,2004		
	J		30. Name and address of person who co	- 301 Ho	1 (Item 23a) (Type,	Drive	GlenBur	rie.	MD 2101	01		
	Sta	•	31. Date filed (Month, Day, Year)	32, Registrar's	s Signature	1		-		<u> </u>		
ur.	Registra	ar ÷	DEC 1 0 2004	Carre Comment	0	Sparker	/					

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Spark

State of Maryland / Department of Health and Mental Hygiene AMEND item #10b Per FH G848 40 126 1405 1 Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Month Vear Maggie J. Morris /Medical December 2004 6:00 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Center Crofton

Anday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Crofton Convalescent & Rehab. Anne Arunde1 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1 □ M 2 🗗 F 92 Yrs. Director 249-24-5194 Feb. 20 1912 S. Carolina Usual Residenca of Decedent 10b. Count Greenville 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified at Director 1 X Yes 2 ☐ No Sparbenburg Carolina Taylor's 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? item 27 is marked other than "natural", or itams 23a or other traumatic event, the Wed call Examinar mast be 5 Lincoln Road Completed by Funeral 29687 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. iiled within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 31 Widowed 4 □ Divorced Specify: Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If Item 27 is marked other th any injury or other traumatic according to the page 200. 10th Garment Factory Presser 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Christopher C. Johnson 2 Clara Lattie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13413 Youngwood Turn Bowie, Maryland Date 20c. Location - City or Town, State Chris Morris (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Enore Baptist Church 12/11/04 Greer, S. Carolina 20a. Method of Disposition XDXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cometery Name and Address of Facility 821 West St. Annapolis, Md. 21. Signature of Funeral Service Licensee Zarry J., Rec. 166483 Wm. Reese & Sons Mortua

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on extensions. Wm. Reese & Sons Mortuary, 21401 Approximate Interval Between Onset and Death Immediate Cause (Final disease of condition resulting in death) **Physician** /Medical Due to or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of): Examiner ox 68760, burial-transit and Due to (or as a consequence of): Box 68760. signed by the attending physician I be detached for use as the buria Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. 1 Yes 2000 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, MIM 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 1 Tyes 2 ER/Outpatient 3 DOA in by the funeral 27. Manner of De th 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: within 24 hours after death. To the Funeral Director: After 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide To the Hospital completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ADITYA CHOPRA, MD. GOORIGELY Ste 231 Annapolis, MD. 21401 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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	1 - Stete Registrar  1. Decedent's Name (First, Middle, Las	t)	Certificate of Death	Reg. N	10. 2004 391
Physician	Shi-lee A	n. ( ===================================			yeer 3. Time of Dea
/Medical Examiner	4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of De		c. County of Death
Examiner	A	Sholle Traumale	Saltino	0	N/A
Funeral Director	5. Social Security Number 6. S		birthday) If Under 1 Year If Under 24 H Months Days Hours M		9. Birthplace (State or Fo
	Usual Residence of Decedent				PIANTUAND
how	10a. State 10b. County		own or Location		10d. Inside City Li
or 28e-f show	MD. ANNE ARUN	DEL ARNO			1 <b>∑</b> Yes 2 [
Dire	10e. Street and Number		10f. Zip Code	10g. C	citizen of What Country?
s 23g	35 OLD FREDERIC	K RD.  12. Was Decedent Ever in U.S.	21012	/Specify Vec or No	USA 14. Race - American Indian,
office and Funeral	11. Marital Status  1     Never Married 2    Married	Armed Forces?	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	erto Rican, etc.)	Black, White, etc.
by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	1	Specify: BLACK
"nati	15. Decedent's Ed (Specify only highest gra		Sa. Decedent's Usual Occupation (Give kind of work done during most of v life. DO NOT use retired)	vorking 16b.	Kind of Business/Industry
t. the Medical I	Elementary/Secondary (0-12)	College (1-4or 5+)	NEVEX WORKED		
T = 5 0	-11- 17. Father's Name (First, Middle, Last)			ame (First, Middle, Maide	en Sumame)
rice of To B	ABRAHAM N. PARK	ER	MARY	F. JOHNSON	
7 is marke 7 is marke treumatic TO	19a. Informant's Name/Relationship (7	170	9b. Mailing Address (Street and Number or		or Town, State, Zip Code)
- N -	ABRAHAM R. PARK	ER (BROTHER)	0 BELLE CT. ANNAPOL	IS, MARYLANI	21401
item 2	20a. Method of Disposition	como	of Disposition (Name of tery, crematory or other place)	Date 20c.	Location - City or Town, State
it o	1 ♣ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		GATE MEMORIAL PARK 1	2-9-2004 ANN	APOLIS MARYLAND
Department of Importent: If its any Injury or of ODCS.	21. Signature of Funeral Service Licen	LARRY REESE	22. Name and Address of Facility W 821 WEST ST. ANNA		
ysician and burial-transit animal transit cal Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence.  Due to (or as a consequence.  Due to (or as a consequence.	e of):  De of):  One of:	THE BY MEDICAL ELAMINES	Onset and Dea
by the attending pt ached for use as th hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes, 2 □ No 9 □ Miknown  Part II. Other significant conditions or	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery  Month Day Year
been signed I should be det leted by P					2 ☑No 3 ☐ Probably 4 ☐Unkr
cate has been s. page 2 should			-	24a. Was an autopsy performed?	24b. Were autopsy findings avairable prior to completion of cause death?  1 Yes 2 No
certificate rector, pag	25. Was case referred to medical examination	Hospital:	Othor	eath (Check only one)	• <b>T</b> 0
oral direction of the control of the	1 🖼 fes 2 □ No 27. Manner of Death	28a Date of Injury 28h	Time of 28c. Injury at	Home 5 Residence 28d. Describe how inj	
e funer atlon	1 □ Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year)	Injury Work? .U20 M 1□Yes 2⊡No	Pederto	inn vi tout
by the fu	3 Suicide 6 Could not be determined				and Number or Rural Route Number, to) LITCHIC Haway nec
등의 보		ysicien: To the best of my knowled	ge, death occurred at the time, date and pla	ce, and due to the cause(	had been and due to the cause (a)
unerel Director: After the funeral prince of the funeral cal Certification:	29a. Certifier 1 Tertifying Phy			curred at the time. Cate al	IN DIACH, ALIA QUE IN ITIE CAUSE(S)
Medical Cert	29a. Certifier (Check only one)  1	iner: On the basis of examination and manner stated	29c. License number		ate signed (Month, Day, Year)
he Funer pletely fill	(Check only 2 Medical Examone)	and manner stated	29c. License number		
To the Funerel Direction completely filled in Medical Cert	(Check only 2 Medical Examone)	and manner stated	29c. License number		

		•	For State Registrer	State of Maryland	d / Depa <i>Cer</i>	artment of H	ealth and M Death	lental Hygie	200	4 39	157
			1. Decedent's Name (First, Middle, Last	)				2. Date of Death Month	Day Y	'ear	ne of Death
	Physicia /Medic		Richard	Charles		Nowak		December	8, 200	06:	40AM M
	Examin		4a. Facility Name (If not institution, give				Location of Death		4c. County of		
			Southern Marylan		at historia.	Clinton	If Under 24 Hrs.	8. Date of Birth		George  Birthplace (St	
	Funeral Director		5. Social Security Number 6. Se 070-16-6352	x 7. Age (In yrs. It	Yrs.	Months Days	Hours Min.	May 30,1	919 N	lew York	ate or roreign
			Usual Residence of Decedent								
	how		10a. State 10b. County		, Town or Lo						de City Limits
	Ba-f s	cto	Maryland Prince G	George's	Cli	nton					Yes 2∏No
	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f show do other than "natural", or items 23a or 28a-f show event, it is Medical Exactinal natural be notified at	Funeral Director	10e. Street and Number 8906 Marquis Lar	ie		10f. Zip Code 207	'35	100	. Citizen of Wh U.S		
	death	nera	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. V	Was Decedent of Hi	spanic Origin? (Spo n, Mexican, Puerto	ecify Yes or No-		American India White, etc.	ın,
9	after or Ita	/Fu	1 Never Married 2 Married		44-	Tes, specify Cuba	Specify:	riicari, etc.)	Specify.		
	hours ural',	d by	3 ₩ Widowed 4 Divorced	Year or Dates: 194	48			146			
2	n 72 "nat	lete	15. Decedent's Edu (Specify only highest grad	le completed)	(Give	lent's Usual Occupa kind of work done o DO NOT use retired	lurina most of work	ing	6b. Kind of Busi	10SS/InduStry	
7	with liene. r than	Completed	Elementary/Secondary (0-12)	4+ <sup>College (1-4or 5+)</sup>	Mecha	nical Eng	ineer	N	aval Re	search	Lab.
2	e filec al Hyg othe vant,	BeC	17. Father's Name (First, Middle, Last)	NT 1				e (First, Middle, Ma			
7	should b ind Ments marked umatic e	To E	Rudolph	Nowak	405 14-15	Add (Charles	Elizabe and Number or Rura		Amberg	<u></u>	
2	and 2 sh Balth and n 27 is n		19a. Informant's Name/Relationship (7) Monica Noe11	/pe, Print)			rive Pri				5
Ę,	of Heal		20a. Method of Disposition	20b. PI	ace of Dispo	sition (Name of natory or other plac	Dec.	,	c. Location - Ci	ty or Town, Stat	te
=	Pages nent of I ant: If Its ury or o		1 ⚠ Burial 2 ☐ Cremation 3 ☐ F `4 ☐ Donation 5 ☐ Other (Specify)	Mar	yland	Veterans	Cemetery	2004 CI		am, Mary	yland
Daillino	permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, If a Medical Examiner must be notified at once.		21. Signature of Furieral Service Incens	e Funeral a Ferry l			MD 20735				
H			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	valions that caused the death	. Do not ent	er the mode of dying	g, such as cardiac	or respiratory arres	t,	Approx	cimate Il Between
	Physician		Immediate Cause (Final disease or condition	A THERES	CZ6	- ROTIC	C HEI	DAT D	ISEAS	C Onset	and Death
	/Medical Examiner		resulting in death)	Due to force a conseque							
		-	Sequentially list conditions, if any, leading to immediate	b. A RT CRID So Due to (or as a consequ	ience of):	. 677	THROUVE	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	PIZCE	~	
	ured i insit	Examiner	cause. Enter Underlying Cause (Disease or injury	RENAL	PI	PILUK	26				
ב ב	be executed ician and burial-transit		that initiated events resulting in death) Last	c. LENAC  Due to (or as a consequence)  Due to (or as a consequence)  Description of the consequence of the	ience of):	11 10 500	CAR	Pi 35	POSE		
00/0	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Medical	(	d. PERIPHER	CAC	Un-C		-//			
X	The law requires that the death certificate ite has been signed by the attending phys page 2 should be detached for use as the	/Me	IF FEMALE:	23c. If yes, outcome of pregnal	ncy				23d. Date of	of delivery	
200	atten 1 for u	cian	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			Month		Year
Ċ	the d by the ached	hysl	9 Unknown	9□Unknown							
,	s that	by P	Part II. Other significant conditions co	ntributing to death but not resu	Ilting in the u	PA/C	en in Part I.			ute to the cause	
ő	en sig	ed t	CDN66 STI	A PERGL		17/20		1 🗌 Yes	2 No 3	Probably 4	↓ □Unknown
ecords,	S 25	Completed	ADVA MED	AGE				24a. Was an autopsy	pric	ore autopsy findi or to completion	ings available of cause of
	Physician: The law r this certificate has b rat director, page 2 s	Con	META BOLL	AC128-	,/_	a		performe 1 ☐ Yes 2 ∑	No 1	ath? ]Yes 2√∑ No	1
VII C	ician certifi ector	Be	25. Was case referred to medical examiner?	Hospital:		Othe	20	h (Check only one)			
5	Phys	: To	1 Yes 2 No	1€ Inpatient 2 □ 1	ER/Outpatien 28b. Time of	3 DOA	4   Nuising no	me 5 Residence 28d. Describe how			
	th. th. taftel	ıtlon	Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury		k? Yes 2 □ No				
VISION	Atter ector by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify		eet, factory, office		26f. Location (Stre		or Rural Route	Number,
5	ital or irs after irat Dii										
	To the Hospital or Attending Physician: The I within 24 hours after dash.  To the Funaral Director: After this certificate he completely filled in by the funeral director, page	edical	29a. Certifier **X Certifying Phy (Check only one) 2 • Medical Exem	rsician: To the best of my know iner: On the basis of examinat and manner stated.	wledge, death ion and/or in	n occurred at the time vestigation, in my op-	ne, date and place, pinion, death occurr	and due to the cau red at the time, date	se(s) and mann a and place, and	er as stated.  I due to the cau	ıse(s)
	To the To the comp	Me	29b. Signature and title of certifier	M Loo	MI	29c. License	e number	290	Date signed (	Month, Day, Yea	ar)
	14		30. Name and address of person who co	ompleted cause of death (Item	23a) (Tyne	Print) DAI	1/20	6. 2	56 /	20	
1	17.		7700 OCP	BRANCH	AV	E., C	UN7	-0 N	· h	18 20	235
	Sta Registr		31. Date filed (Month, Day, Year) <b>DFC 1 0</b> 2004	32. Registrar's Signar	dure,	Som Val					
	, region	G,	DEC 1 0 2004	100 17		1					

				For State Registrar	State o	f Ma	aryland	l / Dep <i>Ce</i>	artmen <i>rtificat</i>	t of H	lealth a	and N	fental Hy	ygiene Reg. No	20	04	39	158
		Physici	an	1. Decedent's Name (First, Middle									2. Date of D Month	Da	,	Year	3. Time of D	
		/Medic			Edward (		Nash,	Sr.	4 07		1 2	(5)	Decemb			004	9:45	A. M
		Examin	er	4a. Facility Name (If not institution, 2105 N. Rolling)	-	nber)				odla	r Location o IWN	of Death		1	-	of Death		
7		Funeral			6. Sex	7. Age	e (In yrs. la	st birthday,	If Under	r 1 Year	If Under	24 Hrs.	8. Date of B				place (State or	Foreign
0	н	Director		215 09 6700	1 <b>3</b> € M 2 🗆 F		88	Yrs.	Months	Days	Hours	Min.	8. Date of B. (Month, D April	28,19	916	Mai	ryland	
+		pu *		Usual Residence of Decedent  10a. State 10b. County			10c City	Town or L	ncation							1	10d. Inside City	Limite
<i>J</i>		Aarylan I show	ō	Maryland Balti	more		-	odlaw									1 ☐ Yes	
à		the Market 288-1	rect	10e. Street and Number					10f. Zip	Code				10g. Cit	zen of W	/hat Cour	ntry?	
		23a or	ai Di	2105 N. Rollin	ng Road					2124	14				U.S.			
		ems S	iner	11. Marital Status	12. Was Dece Armed Fo	dent E	Ever in U.S	. 13.	Was Dece	dent of Hi	ispanic Ori	gin? (Sp	ecify Yes or N Rican, etc.)	0~		- Americ	can Indian,	
13	36	s afte	y Fu	1 ☐ Never Married 2 ☐ Marri 3X Widowed 4 ☐ Divorced	ed 1 □ Yes If Yes, Giv Year or D	е	10		1 ☐ Yes							Whi		
Am	5-0036	within 72 hours after death with the Maryland liene. r than "natural", or Items 23a or 28a-f show Item Medical Exarts as inust Let rediffed at	Completed by Funeral Director	15. Decedent	s Education	1165.		16a. Dece	dent's Usua	al Occupa	ation			16b. K	nd of Bu	siness/In	dustry	
5	215	hin 72 an "na Media	piet	(Specify only highes Elementary/Secondary (0-12)	College (1	-4or 5	+)		kind of wo DO NOT u		during mos f)	t of work	ing					
7:4	21	filed within Hygiene. Ithar than "	Com		4 yea	rs		Acc	ounta	ınt							Credit	5
9	Maryland	be d la la la la la la la la la la la la la	Be	17. Father's Name (First, Middle, I	<sub>ast)</sub> ⊇ A. Nash						18. Mothe		e (First, Middle ah B. K			9)		
0	ž	should ind Men marka umatic	Į.	19a. Informant's Name/Relationsh				19b. Maili	na Address	(Street a	an <i>d Numb</i> e					State. Zic	Code) 210	260
0	S	s 1 and 2 should f Health and Men itam 27 Is marka othar traumatic		Carole N. Hou													Maryla	
0	J.	of Health of Health litam 27 l		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	2 Domoval from	Stata	20b. Pla	ce of Disp	sition (Nar	ne of ther place	ю)		Date	20c. Lo	cation -	City or To	own, State	
0	Ĕ	Pages ment of I ant: If its ury or o		`4 □Donation 5 □ Other (Sp		State	Cres		n Cem	-			/2004	1			iarylan	d
Expires	Baltimore,	permit. Pages Department of I Important: If its any injury or of		21. Signature of Funeral Service L	icensee	u	she	4	2. Name an 201 R:	itch:	ss of Facilities ie Hi	<sup>y</sup> Go ghwa	nce Fur y Ba	neral ltimo	Ser ore,	vice Mary	, P.A. /land 2	1225
	Fe <sub>2</sub> <sup>2</sup>			23a. Part1. Enter the disease, of shock, or heart failure.	complications that conly one cause on e	aused ach lin	the death. ie.	Do not en	ter the mod	le of dying	g, such as	cardiac (	or respiratory a	arrest,			Approximate Interval Between Onset and De	een
		Physician		Immediate Cause (Final disease or condition resulting in death)	a. //	12	MA	MI	12								14111	15
		/Medical Examiner	Ŋ.	resulting in dealiny	Due to	or as	a conseque	nce of):								-	· / gr	
			er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. ————————————————————————————————————	orasa	a conseque	ince of):										
		outed id ansit	Examiner	that initiated events	C.													
	ó	be executed ician and burial-transit	Exa	resulting in death) Last	Due to	orasa	a conseque	ence of):										
	8760,	icate be ex physician s the burial	dicai		d		-									-		
()	9 xo	that the death certific ed by the attending p detached for use as	Physician/Med	IF FEMALE:	23c. If yes, out	come	of pregnan	ev							23d Date	of delive	an/	
V	Bo	atten d for u	ician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live b 4 ☐ Pregn	irth ant at	2 Fetal of time of dea	leath 3[	□Ectopic pr □ Other (sp						Mon			ear
1	0	it the di by the tached	hysi	9 Unknown	9□ Unkno	wn												_/
15	S, D	es gu pe	by	Part II. Dther significant condition	s contributing to de	ath bu	ut not result	ing in the ι	nderlying c	ause give	en in Part I.						ne cause of dea	
A	Vital Records,	v requir been si should	Completed											Yes 2		3 Prob		
2	3ec	elaw hasb ye2st	mpie		/								24a. Was		246. W	ere auto for to cor eath?	psy findings av	railable use of
	alF			OS Miss and reference of the lives						_			1 ☐ Yes	310 No	1	Yes	2 No	
2		sicia s certi	To Be	25. Was case referred to medical examiner?  1 ☐ Yes ☐ No	Hospital:	npatie	nt 2□E	B/Outpatie	nt 3□ DC	Othe	0.00		n <i>(Check only)</i> me 5 ☑ Res		. □Othe	r (Specifi	v)	
Z	J Of	Attending Physician: The rideath. sctor: After this certificate his property the funeral director, page	n: T	27. Manne of Death	28a. Date	of Injur		8b. Time o		8c. Injury Work			28d. Describe				·/	
3	Sior	ttendin death. stor: Afl	atio	1 Patural 5 Pending 2 Accident investig	ation	,,		,,	М		Yes 2 □ I							
7	Division	or Att fter de Siract in by t	Certification:	3 Suicide 6 Could n 4 Homicide	fed 28e. Place		ry - At hom c. (Specify)	e, farm, st	reet, factory	, office			28f. Location ( City or To	(Street an wn, State	d Numbe	r or Rura	l Route Numbe	9 <i>r</i> ,
Eduare		pital		29a. Certifier 1 Certifying	Physician: To the	best o	of my know	ledge, deat	h occurred	at the tim	ne date an	d place.	and due to the	cause(s)	and man	ner as st	ated	
-		To the Hospital or Attenwithin 24 hours after deati To tha Funaral Diractor: completely filled in by the	Medical		xaminer: On the ba	sis of	examination											
		To the Hospital or Attendi within 24 hours after death. To tha Funaral Diractor: A completely filled in by the fu	Me	29b. Signature and title of certifier	A.	2	111	7	290	. License	number	4 :		29d. Dat	e signed	(Month,	ay, Year)	
				Mulla/	WIMAN	//	ML	/	6	11/3	30/	2		18	-5	///	14	
		7		30. Name and address of person	no completed caus	e of de	eath (Item 2	(3a) Type.	Print)	non	1	PS/	Roll	1/1	11	11	2101	o/
1.		Sta	to	31. Date filed (Month, Day, Year)	32. R	egistra	ar's Signatu	7///// re	W UJ	USUP	/	9	Nal,	10,	11/	1 -	44	1
7	151 153	Registr					we	13	plays	ociti	200							

State of Maryland / Department of Health and Mental Hygien 20 39159 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Paul Nahnibida DEC 05 2004 9:40A /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Future Care Chesapeake Arnold. Anne Arundel 6. Sex 1 M 2 ☐ F 8. Date of Birth (Month, Day, Year) Aug 24, 1920 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign MD ) **Funeral** 84 214-12-0438 Director Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Director Anne Arundel Glen Burnie 1 ☐ Yes 2 → No 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 506 Second Avenue S.W. 21061 Completed by Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1∆ Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐No Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Civil Engineer Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Nikiphor Nahnibida Ludwina Solonynka ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Rita Nahnibida / wife 506 Second Avenue S.W., Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Dec 10,2004 Crownsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral Home P.A. 1 Second Avenue S.W., Glen Burnie, MD 21061 ceula Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) metastalic Prostate Carcinoma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-transit The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Delirium 1 Yes 2 W 3 Probably 4 Unknown has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an this certificate 1 Yes 2 No or Attending Physiclen: : After this certifical funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 1 No Hospital: Cther: 4 ☐ Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 🗋 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural s after decree After 5 Pending 1 ☐ Yes 2 ☐ No investigation М 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei Medicai (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Dec 06, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kerry 2601 Vetera Maket Neg millersville 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 1 0 2004 Registrar

			1- State of Maryland / Department of Health and Mental Hygien 39   6 ( Certificate of Death Reg. No.	)
	Physi /Med		1. Decedent's Name (First, Middle, Last)  WILLIAM C. OHRMANN  2. Date of Death  Month  Day  8th Year  7 700 P	vI
	Exam	iner	4a. Facility Name (If not institution, give street and number)  1	al gn
	Directo		215-14-9301 1 M 2 F 85 Yrs. Months Days Hours Min. Jan. 1, 1919 Maryland Usual Residence of Decedent	
	Maryland f show	ō	10a. State10b. County10c. City, Town or Location10d. Inside City LimitMarylandAnne ArundelPasadena1 Dyes 20N	
	th with the P 23e or 28e-	ai Director	10e. Street and Number 8102 Sprague Drive 10f. Zip Code 21122 USA	
	more, Maryland 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other then "naturel", or Items 23e or 28e-1 show my or other traumatic event, the Medical Examinar must be notified at	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Amed Forces?  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Amed Forces?  1 Mary Security:  13. Was Decedent of Hispanic Origin? (Specify Yes or No-Black, White, etc.)  14. Race - American Indian, Black, White, etc.  1 Mary Security:  14. Race - American Indian, Black, White, etc.  1 Mary Security:  14. Race - American Indian, Black, White, etc.  1 Mary Security:  15. Was Decedent of Hispanic Origin? (Specify Yes or No-Black, White, etc.)  16. Yes, specify:  17. Was Decedent of Hispanic Origin? (Specify Yes or No-Black, White, etc.)  18. Race - American Indian, Black, White, etc.  19. Yes 2 No Specify:  10. Yes 2 No Specify:  10. Yes 2 No Specify:  11. Yes 2 No Specify:  11. Yes 2 No Specify:  12. Was Decedent of Hispanic Origin? (Specify Yes or No-Black, White, etc.)	
	Maryland 21215-0036 to 2 should be filed within 72 hours aft th and Montal Hygiene. 27 is marked other then "naturel", or traumatic event, the Medical Exami	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/Industry	
	1 212 lled withi tygiene. her ther nt, the N		Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator Lever Brothers  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)	
	ylanc buld be fi Mental H arked ot	To Be	Herman Ohrmann Charlotte Lohmeyer	
	Mar and 2 sho alth and 27 is mar		19a. Informant's Name/Relationship (Type, Print)  Ada E. Ohrmann (Wife)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  8102 Sprague Drive, Pasadena, Md. 21122	
	Baltimore, permit. Pages 1 ar Department of Heal mportent: If them any injury or othe		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State '4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Parkwood Cemetery  20c. Location - City or Town, State  12/11/2004  Baltimore, Maryland	
	Baltimo	SIICE	21. Signature of Funeral Service Licensee Kevin E Ecker McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road, Pasadena, Md. 21122	
	Pnysicial /Medica		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or rest iratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	
2	Examine	r	1 al ets	
moon	cate be executed physician and the burial-transit	dical Examine	Sequentially list conditions, if any, leading to first ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	
Jhr	O. BOX 6 Ne death certifi the attending I the death of the asset of th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	
	ds, P. lires that it signed by	b	Part II. Other significant conditions contributing to death but not resulting in the funderlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1   Yes 2   No 3   Probably 4 Unknown	n
3	Record The law require te has been signed 2 should be	Completed	24a. Was an autopsy findings available autopsy performed? 1	Э
201	Vital	o Be C	25. Was case referred to medical examiner?  Hospital:  Other:	
	<b>O</b> & = E	H-	27. Manner of De th  1 Deading  28a. Date of Injury  28b. Date of Injury  28b. Injury at Work?  (Month, Day Year)  28c. Injury at Work?	
$\geq$	Division To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Alter completely filled in by the fune	ertification;	2 Accident investigation 3 Suicide 6 Could not be determined 6 Homicide 6 Homicide 6 Homicide 1 See. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	Hospite 24 hours Funere	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
4	To the within To the comple	Me	29b. Signature and file of certifier  D48006  Decimber 700	4
_	104	1	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital Dr., Glim Brown, m	D
	Regi	State strar	31. Date filed (Month, Day, Year)  32. Registrar's Signature  DEC 1 0 2004  September & Aparels	

		1	State of Maryland / Department of Health and Mental Hygiene 39161
			1. Decedent's Name (First, Middle, Last)  2. Date of Death  3. Time of Death
	Physicia /Medic	al _	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
	Examin	er	Harber Hospital Center Baltimore City NA
	Funeral Director		5. Social Security Number 236 30 1994 12 F 77 Yrs. 7. Age (In yrs. last birthday) 15 Under 1 Year 16 Under 1 Year 17 Under 1 Year 17 Under 1 Year 17 Under 1 Year 17 Under 1 Year 18 Under 1 Year 18 Under 1 Year 18 Under 1 Year 19 Under 1 Year 18 Under 1 Y
	ylend	- h	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	8a-fsh	ctor	Maryland N/A Baltimore 12€ Yes 2□No
	3a or 2	Dire	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?  3703 Everett Street 21225 U.S.
036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylend Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Midical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 Never Married 2X Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Amed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 15X Yes. 22 No 16 Yes, Give Year or Dates: WW II
21215-0036	72 ho natur	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/Industry
121	iene. r than	dmo	Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Domino's Sugar
nd	be filec tal Hyg d othel	BeC	17. Father's Name (First, Middle, Last)  Jerry Oliver  18. Mother's Name (First, Middle, Maiden Sumame)  Rosalena Boley
Maryland	should id Men marke matic	ဥ	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Σ,	end 2 selth ar n 27 is er trau		Eloise Oliver / Wife 3703 Everett Street Baltimore, Maryland 21225
Baltimore,	Pages 1 of He nt: If Iten ry or oth		20a. Method of Disposition  1 ▼Burial 2 □ Cremation 3 □ Removal from State  1 □ Donation 5 □ Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Meadowridge Mem Park  12/10/20Q4  Elkridge, Maryland
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 2122
			23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate Interval Between Onset and Death  Immediate Cause (Final
	Physician /Medical		disease or condition resulting in death)  Due to (or as a consequence of):
	Examiner	er	Sequentially list conditions, if any, leading to immediate  b. Small bowel obstruction  Due to (or as a consequence of):  Due to (or as a consequence of):
	nd nd transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events c.
8760,	cate be executed physician and the burial-transit	al Ex	resulting in death) Last Due to (or as a consequence of):
W.		ledical	d.
.O. Box	The law requires that the death certift ate has been signed by the attending bage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1
s, P.	es that the gned by be detac	by Ph	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?
ords	w require been sig should b		1 XYes 2 No 3 Probably 4 Unknown
Record	The law are has by page 2 sh	Completed	
Vital	Phyeicien: Th rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?  Hospital: Other: Charles of Death (Check only one)
of	Phyer this ral di	n; To	27. Manner of Death  28a. Date of Injury 28b. Time of Section 1 2bb.
sion	Attending Fir death. ector: After by the funer	catlo	2 Accident investigation M 1 Yes 2 No
Division	F. 5. #6	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospitel or Attenwithin 24 hours after deal To the Funerel Director: completely filled in by the	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	To th withir To th comp	Me	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)
1			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tanader Mira / Harbar Harbar
7	7		3001 SHanova St. Baltimon MD 21225
	St Regist	ate rar	31. Date filed (Month, Day, Year)  DEC 1 0 2004  32. Registrar's Signature

Please Type or Print in Black Indelible ink Ensure All Copies Are Legible.

Amend 1tem#20b-c.perFH C838, 12/10/04 TT

State of Maryland / Department of Health and Mental Hygiene Officers

			1 - For State Registrar Cer	tificate of Death		2004 39162
	Physicia		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death
	/Medic		Dorothy Overdick		Dec.	6, 2004 7:10 P M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
		4	Millennium Rehab. Center  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Baltimore If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	N/a 9. Birthplace (State or Foreign
	Funeral Director		5. Social Security Number  212-76-0203  Output  6. Sex 1 M 20 F 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday)	Months Days Hours Min.	(Month, Day, Y	(ear) Country)
	land ow		10a. State 10b. County 10c. City, Town or Lo	cation		10d. Inside City Limits
	Many a-f sh	Ş	Md. N/A Baltimor	·e		XX Yes 2 □ No
	or 28g	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Country?
	23e (23e)	la	1217 West Fayette St.	21223		U.S.A.
21215-0036	be filed within 72 hours after death with the Maryland nat Hyglene. d other than "neturel", or Items 23e or 28e-f show event, its Medical Evaritier must be notified at	by Funeral	1 Never Married 2 Married 1 TYes 2 NNo	Was Decedent of Hispanic Origin? (Spf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
Q 2	72 ho netur	Completed	15. Decedent's Education 16a. Decedent's Education (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	king 16	6b. Kind of Business/Industry
2	within iene.	nple	Elementary/Secondary (0-12) College (1-4or 5+)			N/A
121	filed w Hygier other th		0 Dis	able 18 Mother's Nam	e (First, Middle, Ma	
Maryland	il be fil ntal H ed ott	o Be	George Overdick		Sluzcwski	
2	2 should be and Mental Is marked o	ĭ		ng Address (Street and Number or Rui		City or Town, State, Zip Code)
	2 8 8 8		Joan Brofka / Niece 785	5 Lockwood Rd., D	undalk, N	Md. 21222
Baltimore,	iter of H		Baltimore	-wash. Crematory	.2- 8-04	oc. Location - City or Town, State  Laurel Md.
alti	permit. Page Department of Important: If eny injury or once.		21. Signature of Funeral Service Licensee	ort Crematory . Name and Address of Facility radley—Ashton—Mat		lexandria, VA
<u>m</u>			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent			
	Pnysician		Immediate Cause (Final disease or condition a. Allego Substitution probability in the condition as the condi	Cordio von los o	liser-re	-
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):			
	*	L.	Sequentially list conditions, Larry leading to immediate  Due to (or as a consequence or).			
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury			
,	execu n and ial-tra	Exal	that initiated events resulting in death) Last c. Due to (or as a consequence of):			
68760,	icate be executed physician and s the burial-transit		d			
	tificat ng phy as th	Medical				7707
O. Box	ath cer attendir for use	Physician/N		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
ecords, P.	juires that the de n signed by the a ild be detached i	by	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.		ccco use contribute to the cause of death?
00	w requires been si	olete			24a. Was an	24b. Were autopsy findings available
$\mathbf{\alpha}$	The lav	Completed			autopsy performe	prior to completion of cause of death?  No 1 Yes 2 No
Vital		BeC	25. Was case referred to medical	26. Place of Dea	th (Check only one)	
Į <	ysicien: is certific director,	To E	examiner? 1   Yes 2 No   Hospital: 1   Inpatient 2   ER/Outpatient	nt 3 DOA Cther: 4 Nursing H	ome 5 🗆 Residen	ce 6 Other (Specify)
n of	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	28d. Describe how	v injury occurred
Division	Attending Physicien: r death. ector: After this certifications the funeral director.	Certification;	2 Accident investigation	M 1 Yes 2 No	206 Location (Ctra	and Alumbar or Dural Paula Alumbar
Νį	or Att	ırtifi	4 Homicide  4 Homicide  4 Solution Research State See Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	City or Town,	net and Number or Rural Route Number, State)
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat	h occurred at the time, date and place	, and due to the cau	use(s) and manner as stated.
	Hos 24 hc Fun etely	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occu	rred at the time, date	e and place, and due to the cause(s)
	o the	Me	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month, Day, Year)
	->-0		> DESOL10	リ 17557		12-7.04
	Ø		30. Name and address of persog who completed cause of death (Item 23a) (Type, DARCHAN S, SHLU/MM)	G Soak	Il Ave,	, Balto 21217
	Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	G frank		

N	712		For	/ Department of Health and I Certificate of Death		20163
1			Stete Registrer  1. Decedent's Name (First, Middle, Last)	Certificate of Death	Reg. Reg. Reg. Reg. Reg. Reg. Reg. Reg.	3. Time of Death
A A	Physicia	n	JAMES WILLARD	POWELL JR.	December 5	8, 2004 0043 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death
	Zxamm		Shock Trauma	Baltimore		NIA
	Funeral Director		5. Social Security Number 6. Sex 1.2	t birthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yea DEC, O2, 1	9. Birthplace (State or Foreign Country) MARY LAND
	land		Usual Residence of Decedent           10a. State         10b. County         10c. City, T	Town or Location		10d. Inside City Limits
	72 hours after death with the Maryland natural', or Items 23s or 28s-f show dical Evanting Frust ke modified at	to	YARII AND NIA	BALTIMORE	CITY	1ÆYes 2□No
	or 28g	Director	10e. Street and Number	10f. Zip Code	1,0g. (	Citizen of What Country?
	23a		(309 S. STRICKER S	5T. 2122	13	USA.
	er des Items	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	rs aft	by F	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 ☎ No Specify:		Specify: 21 AC 1/
21215-0036	2 hou	ted	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work	16b.	Kind of Business/Industry
215	within 7 ene. than "r	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)	Ning .	/ .
	filed wi Hygier other th		17. Father's Name (First, Middle, Last)	UNEMPLOYED  18 Mother's Nar	ne (First, Middle, Maid	en Sumame)
and	2 should be filed withir and Mental Hygiene. Is marked other than aumatic evant, It e Mi	Be c		UELL SR. BRIE	CETT	H HALL
3altimore, Maryland	should nd Men marke	၀	9	19b. Mailing Address (Street and Number or Ru	ural Route Number, City	y or Town, State, Zip Code)
	1 and Health em 27 ther tr		BRINGETT HALL (MOTHER)	309 SOUTH STRICK	ER ST. BA	LTO. MD. 21223
			20a. Method of Disposition  20b. Plac  20b. Plac  cem  20b. Plac  cem	ce of Disposition (Name of netery, crematory or other place)	Date / 20c.	Location - City or Town, State
	Pages ment of I ant: If its ury or o		'4 □Donation 5 □Other (Specify) MT,	ZION CEMETERY 12-	18-04 LA	+NSDOWNE, MD.
Balt	permit. Pag Department Important: any injury o		21. Sign full of Fureral Service Licensee	2 140 N. FULTO	NAVE., O	2, FUNERAL HOME ALTO. MD. 21217
	i per		23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition as MULTIPLE (	22. Name and Address of acility BROWN TR, FUNERAL HON  TO SEPH H. BROWN TR, FUNERAL HON  212/ that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and Death on each line.  22. Name and Address of acility BROWN TR, FUNERAL HON  Approximate Interval Between Onset and Death	Ontol and Boam	
	/Medical Examiner		resulting in death)  Due to (or as a consequent	nce of):		
		ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequent of the conditions)	nce of):		
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. As I Ladyling Cause (Disease or injury that initiated events			
oʻ	an an	Exa	resulting in death) Last Due to (or as a consequent	nce of):		
8760	ate be executed hysician and the burial-transit	dicat	d		<del> </del>	
9	requires that the death certifics een signed by the attending pt hould be detached for use as t	/Mec	IF FEMALE: 23c. If yes, outcome of pregnance	;v		23d. Date of delivery
Вох	atten atten I for u	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	eath 3 Ectopic pregnancy		Month Day Year
0	that the death ed by the atte detached for	hyst	9 Unknown			
S, P	res that signed to be det	by P	Part II. Other significant conditions contributing to death but not resulti	ng in the underlying cause given in Part I.		o use contribute to the cause of death?
ord	w require been si	ted			1 Tes	2 No 3 Probably 4 Unknown
ecc	S S S	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
E H	Th ate pag	Co			performed? Yes 2□	? death? No 1 Yes 2 □ No
of Vital Records,	ding Physician: Th h. After this certilicate funeral director, pag	Be	25. Was case referred to medical examiner?  Hospital: Hospital:	Other	ath (Check only one)	0 □0h - (C't-)
o		-: To		18b. Time of 28c. Injury at	dome 5 Residence 28d. Describe how in	
lon	Attending r death. actor: After by the fune	atior		Injury Work? 2:2c A M 1 □ Yes 2 No	SUBTECT	WAS SHOT
Division	Attendii er death. ractor: A by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	e, farm, street, factory, office	City on Toyen Ca	and Number or Rural Route Number, ate)
Ö	ital ou irs aft ral Di led in		STREET			. PRATTST, DALTITORE, M
	To the Hospital or Attendii within 24 hours after death. To the Funeral Diractor: A completely filled in by the fu	edical	29a. Certifier (Check only one)  1 ☐ Certifying Physicien: To the best of my knowledge of the desired form of the past of examination and manner stated.	edge, death occurred at the time, date and place in and/or investigation, in my opinion, death occurred.	urred at the time, date a	and place, and due to the cause(s)
	To the vithing To the complex	Ž	29b. Signature and title of certifier	29c. License number  O.C.M.E.		Date signed (Month, Day, Year) Cember 8, 2004
			· cmex		Dec	
_	3		30. Name and address of person who completed cause of death (Item 2	111 Penn Street, Ba	ltimore, Ma	aryland 21201
4	Sta Registi		31. Date filed (Month, Day, Year) DEC 1 0 2004  32. Registrar's Signatur	& South		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#5,6-19b, perFh, G838,12/15/04 TI

For amend item#20a-c, perFh, G840,2/28/05 TI

Registrar

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month DECEMBER **Physician** 2004 DAVID PITTS 8:25 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Saint Joseph Medical Center lowson 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth 9/29/1919 Birthplace (State or Foreign (Month, Day, 1941)

Rait MD unk **Funeral** 1 X M 2 ☐ F Balt. MD 87 unk Director unk Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Peges 1 and 2 should be filed within 72 hours after deeth with the Maryla nent of Heelth and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23e or 28e-1 show ury or other traumatic event, Ite Madical Examination and be notified at 1 Yes 2 Ne Funeral Director MD unk Baltimore unk unk 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? unk 33 Blister Street unk 21220 unk USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No ff Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify: white 1 Yes 2 No Specify: Completed by 3X Widowed 4 □ Divorced unk 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Sales Rep. Hardware unk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be unk unk David Pitts Claudia Waters 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33 Blister Street Baltimore, MD 21220 unk Davette Pitts unk Baltimore, 20b. Place of Disposition (Name of Fork Union, Va Bremo Bluff, V 20a. Method of Disposition Fork, Union free 1 Can 127 1 Burial 2 Cremation 3 KRemoval from State permit. Pege Department of Important: if any injury or 4 Donation 5 Other (Specify) TE nyuni Sarvice Ligense 22. Name and Address of Facility MARYLAND MORTUARY SUPPORT KELLY GREGORY FINK #M01148 426 CRAIN HIGHWAY S., GLEN BURNIE, MD 21061 23a. Part1. Enter the disease) or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, o heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau (Final disease or condition resulting in death) Physician PNEUMONIA DAYS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or infury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attanding Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetaf death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Year ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4☐ Pregnant at time of death 5 Other (specify) P.0 detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2**X** No Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 70 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA o 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division 1 XNatural 5 Pending investigation М 1 ☐ Yes 2 ☐ No death. 2 Accident Diractor: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) by determined after 4 Homicide within 24 hours a

To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier (Check only one) Medi 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number December 4, 2004 D 17695 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABDA PH OSLER DRIVE. TOWSON MARYLAND 21204 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State 2004 Registrar

			State of Maryland / Department of Health and Mental Hygiene  1- State of Maryland / Department of Death  Certificate of Death	•
	Physici	an	1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day	Year 3 im of Datin 5
	/Medic Examin	al	al. Linda Quille December 6	5 2004 7:20 a <sup>M</sup> County of Death
	Funeral Director		Anne Arundel Medical Center Annapolis Are 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1 May 14 195	nne Arundel  9. Birthplace (State or Foreign Country)  Maryland
	yland how		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	the Ma 28e-f s	Director	Maryland Anne Arundel Annapolis  10e. Street and Number 10f. Zip Code 10g. Citiz	11 ☑ Yes 2 ☐ No zen of What Country?
	th with 23a or	al Dir	ত 615 Greenbriar Lane 21401	USA
36	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28e-f show int, Ite Madical Eranical must be notified at	Completed by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Devorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, Sive No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 Yes, Give Year or Dates:	i4. Race - American Indian, Black, White, etc. Specify: Black
21215-0036	72 hou nature	eted	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Sta	nd of Business/Industry
2121	I within jiene. r than	ompl	Elementary/Secondary (0-12) College (1-4or 5+) 12th 2 yrs. Allowences Differential Speci	te Department ialist
pu	be filed ital Hyg id othe avant,	Be	o 17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden S	Sumame)
Baltimore, Maryland	should nd Men marke imatic	은	Rodney Jones  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene.  Brownstant: If them 27 is marked other than "natural; or Items 23a or 28e-f show any injury or other traumatic avant, It a Marical Examination at the nulling at once.		Carl Jones (Brother)  20a. Method of Disposition  1 ②Burial 2 □ Cremation 3 □ Removal from State  APPROximation 5 □ Other (Secret)  1 ② Secretary	cation - City or Town, State
Balti	permit. Departm Importal Importal any injur		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  23. Name and Address of Facility  Wm. Reese & Sons Mortuar  821 West St. Annapolis,  23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,	y, P.A.
ريد ريد (192)	eath certificate be executed  attending physician and for use as the burial-transit	dlcal Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	Approximate Interval Between Onset and Death
.O. Box 68	D 0 D	by Physician/Med	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	3d. Date of delivery Month Day Year
S, D	The law requires that the ste has been signed by th page 2 should be detache			se contribute to the cause of death?
Vital Record		e Completed	and the state of t	24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No
	Physician: this certifica ral director, I	To Be	examiner?    Sexaminer   Content   C	Other (Specify)
	ding Afte fune	tlon:	27. Mannayer Death 28a. Date of Injury 28b. Time of Injury 1	occurred
Division	Attan r deal actor: by the	Certification:	2 Accident investigation 3 Suicide 4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and City or Town, State)	Number or Rural Route Number,
	To the Hospital or within 24 hours after within 24 hours after To the Funeral Dirt completely filled in It.	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) a construction one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) a construction one)  2 - Medical Exeminar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) a construction one)	place, and due to the cause(s)
)	To To	Σ		signed (Month, Day, Year)
	In		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  With fam's, ma 888 Bestagete Rd Steril Annapolis  31. Date filed (Month, Day, Year)  32. Registrar's Signature	10100
	D Sta	te	With Harris, ma 888 Bestagte Rd Ste 1/1 Annapolis  31. Date filed (Month, Day, Year)  32. Registrar's Signature	mo 7140
ŝ-	Registr	4		

			State of Maryla  State of Maryla	nd / Department of Health and N Certificate of Death	lental Hygier Reg. l	ZIIII 39167
	Physici		1. Decedent's Name (First, Middle, Last)  Claire E. Romeo		2. Date of Death	Day Year 3. Time of Death
	/Medio Examin		4a. Facility Name (If not institution, give street and number) Stella Maris Hospi	4b. City, Town, or Location of Death		4c. County of Death Balfimore Co.
	Funeral Director		5. Social Security Number  3.18-05-7/36  6. Sex 1 M 20 F  7. Age (In yr)  Usual Residence of Decedent	s. last birthday)  Yrs.  If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth Month, Day, Yea June 20,	9. Birthplace (State or Foreign 1914 Balk more, MD.
	hours after death with the Maryland turel', or Items 23a or 28a-f show al Examiner must be notified at	tor		City, Town or Location  WH - HIVY		10d. Inside City Limits 1 ☐ Yes 2 No
		al Director	10e. Street and Number 4/01 Old National Pil	10f. Zip Code 2/77/	10g. (	Citizen of What Country?
936	urs after deat el', or Items '	by Funeral	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  1 Ywas Decedent Ever in Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	U.S. 13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	In 72 n "ne nedic	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)  HOME MAKE	ing 16b.	Nind of Business/Industry  Own Home
Maryland 2	d be filed ental Hyg ked othe c event,	To Be Co	17. Father's Name (First, Middle, Last) George Michael	18. Mother's Name	e (First, Middle, Maid MCC	Chester
_	Pages 1 and ment of Healt ent: If item 2 ury or other		19a. Informant's Merkelationship (Type, Print) Barbara R. Hoover (Niece		Upperco	e, MD. 21155
Baltimore			Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)	Cometery, ciomatory or other place) and De	C. 8, Ti	Location - City or Town, State Tomonium, Maryland
Bal	permit. Departr Imports any inj		21. Signature of Funeral Service Licensee  23a. Part. Inter the (Islanse, or complications that caused the de	. 2325 YOCK Pd.	Timenio	
	Pnysician /Medical		23a. Pakuf. Finter the (Isbase, or complications that caused the de shock, or heart failure. List only one cause on each tine.  Immediate Cause (Final disease or condition resulting in death)  aCARDIOMYOP Due to (or as a cons	ATHY		Inierval Between Onset and Death
	rate be executed hysician and the burial-transit	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			
8760,		ai Examiner	that initiated events resulting in death) Last Due to (or as a cons	equence of):		
Box 687	leath certificate attending phys I for use as the	ın/Medicai	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fe			23d. Date of delivery
P.O. B	at the deatl by the atte	Physician/Me	n me past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  4 ☐ Pregnant at time of 9 ☐ Unknown	f death 5 🗌 Other (specify)		Month Day Year
Ś	The law requires that the death certific ite has been signed by the atlending p page 2 should be detached for use as	þ	Part II. Other significant conditions contributing to death but not r	esulting in the underlying cause given in Part I.		o use contribute to the cause of death?  2 \( \sum \text{No} \) 3 \( \sum \text{Probably} \) 4 \( \frac{\fraccc}\f
al Record		Completed			24a. Was an autopsy performed:	
Vital	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ▼ No Hospital: 1 ☐ Inpatient 2	26. Place of Deat  EP/Outpatient 3 DOA Other: 4 Nursing Ho	h (Check only one) ome 5   Residence	6 <b>X</b> Other (Specify) <b>HOSPICE</b>
n of	ge fe	on: T	27. Manner of Death  1   Natural  1 Pending  28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Injury at Work?	28d. Describe how in	
Division	or Atten ifter deat Director: in by the	Certification:	2 Accident investigation		28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	To the Hospitel within 24 hours a To the Funerel I completely filled	Medicai Co				
	To the within To the comple	Me	29b. Signature and title of certifier	29c. License number	29d. [	Date signed (Month, Day, Year)
,			30. Name and address of person who completed cause of death (II	em 23a) (Type, Print)		10/6/04
	3		DR. TARIQ MAHMOOD 2300 DUL	ANEY VALLEY RD. TIMONIUM	M, MD 2109	3
	Sta Regist		31. Date filed (Month, Day, Year)  DEC 1 0 2004  32. Regispars Signary			

4:10 a.m.

**DECEMBER 4, 2004** 

CLAIRE ROMEO

			1 - For Stata Registrar 1. Decedent's Name (First, Middle, Last)	State of Maryla	•	tment of H		Mental H	Rag. No.	) () ( <sub>t</sub>	39168
	hysicia /Medic		Melvin M. Reid					Month	BER 30	2004	3. Time of Death  2/54/ M
	Examin uneral	er	4a. Facility Name (If not institution, give s  AUT  5. Social Security Number  6. Sex	ES HEACT	HCARE  Vrs. (ast birthday)	13AC	TIMORI If Under 24 Hrs	;		nty of Death  9. Birthpl	ace (State or Foreign
	rector		245-66-3891 1D3	M 2□F	61. Yrs.	Months Days	Hours Min	8. Date of E (Month, 1 03-1.3-	1943 <sup>ear)</sup>	North	Carolina
Maryland	ing at	tor	10a. State 10b. County MD NA	10c.	City, Town or Loca Balt	tion imore				10	od. Inside City Limits 1 Yes 2 No
with the	3a or 28e	i Direc	10e. Street and Number 1716 Ashburton Street			10f. Zip Code 21216			10g. Citizen	of What Coun	try?
1215-0036 within 72 hours after death with the	rai', or itema 23a or 28a-f show Examinar must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		as Decedent of H es, specify Cuba	ispanic Origin? ( In, Mexican, Pue Specify:	Specify Yes or I to Rican, etc.)	i	Race - America Black, White, e	etc.
215-00 ithin 72 hou	an "netural", Medical Exe	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12	ation	(Give kir life. DC		ation during most of wo	orking		f Business/Ind	lustry
Baltimore, Maryland 21215-0036	Important: If item 27 is marked other than "netur any Injury or other traumatic event, I're Madical once.	To Be Con	12 17. Father's Name (First, Middle, Last) Louis Reid		Ass	sembler	18. Mother's Na	me (First, Mida	lle, Maiden Sum	eneral M	otors
, Maryla and 2 should aith and Men	27 is mark er traumati	ř	19a. Informant's Name/Relationship (Typ. Alicia R. Campbell/ Da	nighter	745 Len	mox Stree	and Number or R			wn, State, Zip	Code)
imore, Pages 1 a	ant: If item ury or othe		20a. Method of Disposition  1	BINOVALITORII ŞTATB	b. Place of Dispositi cemetery, cremain ng Memorial		1	Date 1-04		on - City or Tov 1stown,	
<b>Balt</b> permit. Departr	Import any Inj once.		21. Signature of Funeral Service Licens	112.	. Wy1		1 Home 638			lto, MD	21217
	sician edical		23a. Particenter the disease, or complete shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Due to (or as a con-					arrest,		Approximate Interval Between Onset and Death
	Examiner and purial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	kequanea orj	ing Art	y 2.3	ease			lengear
r) X 68760, certificate be executed		edicai							r		
. Bo	ed by the attending phy detached for use as th	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Was decedent pregnant in the past 12 months?  1							ry Day Year
ecords, P.O. law requires that the	been signed b	ed by Pł	Part II. Other significant conditions con	tributing to death but not	resulting in the unde	erlying cause give	en in Part I.			4.0	e cause of death?
I Rec	ate has page 2	Completed						24a. Wa aut per 1 🗆 Yes	topsy rformed?	b. Were autop prior to com death? 1 \( \sum \text{Yes} \)	esy findings available apletion of cause of
Of Vita	After this certificate funeral director, pag	n; To Be	27. Manner of Death	ospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year	201 ER/Outpatient 28b. Time of	3 DOA Other	26. Place of De er: 4 ☐ Nursing	dome 5□Re			)
Division for Attending	Director: After I in by the funer	Certification:	1 Hatural 5 Pending investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp.	At home, farm, street	M 1 🗆	Yes 2 □ No		(Street and Nu own, State)	mber or Rural	Route Number,
Hospitel of the House of the House of the Hours of the Ho	To the Funerel D completely filled in	edicai Ce	29a. Certifier (Check only one)  29a. Certifying Phys 2 Medical Examir	sician: To the best of my nar: On the basis of exam and manner stated.	knowledge, death o nination and/or inves	occurred at the time stigation, in my of	ne, date and place pinion, death occ	e, and due to th urred at the time	e cause(s) and e, date and plac	manner as sta	ated. the cause(s)
To the within 2	To the comple	Mec	29b. Signature and title of certifier	and mainter stated.		29c. Licenso			29d. Date sig	ned (Month, E	
3	b/		30. Name and address of person who co	mpleted cause of death (	Item 23a) (Type, Pri	136581 900 (2)		ne Re			
	Sta Registr		31. Date filed (Month Et 1a'0 200	32. Jegistrar's Si	gnatute	whi .					

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Year December 3. 30 AN Vorma Kögleck 2004 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deat Ellicott City Health & Rehab. Ellicott City Howard If Under Months 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) 6. Sex Hours Days 1 □ M 2 🖾 F 219-28-7808 73 June 22, 1931 Maryland Usuel Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10h Counts 10a State 1 ☐ Yes 21 No Maryland Carrol1 Sykesville 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1256 Guilford Road 21784 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Lest) Norman Meyer Gladys Malonee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Roelecke (Son) 1256 Guilford Road Sykesville, Maryland 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 12-8-04 Sykesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Lakeview Memorial Park 22. Name and Address of Facility Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licensee m00869 1630 Edmondson Avenue Catonsville, MD 21228 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or hear, failure. List only one cause of each line. Attensole 10 Tic Cardiovas cular Diferen Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest Due to (or as a consequence of) Due to (or as a consequence of): o use contribute to the cause of death? 3 □ Probably 4 Unknown 2□ No 24b. Were autopsy findings available prior to completion of cause of death? opsy PU!

inding physician end use as the bunel-trensit or Attending Physician: The law requires that the death certificate be executed Physician/Medical Exami Division of Vital Records, P.O. Box 68760, Š Be Completed Certification: To Director: After thi d in by the funeral within 24 hours efter death.

To the Funeral Director: A completely filled in by the fu

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Physician

/Medical

Examiner

Funeral

Director

28a-f show

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Items 23s

Director

Funeral

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Completed

traumatic event, the Madical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours efter death with the Maryland

I Hygie

Department of Health and Mental important: if item 27 is marked of eny injury or other traumatic eventy injury or other traumatic events.

Physician

/Medical Examiner

Baltimore, Maryland 21215-0020

art II. Other eignificant conditions	contributing to death but r	ot resulting in the und	lerlying caus	e given in Part I.	23b. Did tobacc
					24a. Was an aut performed?
					1L Yes
5. Was case referred to medical				26. Place of Deat	th (Check only one)
examiner? 1 □ Yes 2 □	Hospital: 1 ☐ Inpatient	2 ER/Outpatient	3□ DOA	Other: 4 Nursing Ho	ome 5 Residence
	1	1	100		

		1  Yes 2		
25. Was case referred to medical		Check only one)		
examiner? 1 ☐ Yes 2 ☐	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 2 Nursing Home	26. Place of Death (Check only one)  ent 3 DOA  Other: 4 Aursing Home 5 Residence 6 Other (Specify)  of 28c Injury at Work?  M 1 Yes 2 No		
27. Manner of Deeth  Autural 5 Pending  2 Accident investigation	(Month, Day Year) Injury Work?  M 1 ☐ Yes 2 ☐ No	Describe how injury occurred		
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)		

	122	J. 1, 2,		
29a. Certifier (Check only one)			death occurred at the time, dete end place, and du or investigation, in my opinion, death occurred et the	
29b. Signature en	nd title of certifier		29c. License number	29d. Date signed (Month, Day, Year)

Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Kamesh Sahanalh

D30641 December 6 2007
Erdman Avene Balkmure Maylor 2143

State Registrar

Medical

31. Date filed (Month, Day, Year)

32. Registrer's Signature 2004

1 \_ For

39170

	Ragistrar		Cer	uncate of	Deain	Re	g. <b>No.</b>	
Physician /Medical	Decedent's Name (First, Midd     DEANE	le, Last)		ROBBI		2. Date of Death Month EC.	6 2004 Year	3. Time of Death 6:15 A M
Examiner Funeral Director	4a. Facility Name (If not institute)  5. Social Security Number  210 44 7210	STELLA MARIS		4b. City, Town, o	If Under 24 Hrs. Hours Min.	TIMONIU	M  9. Birtl  Year)  9. Birtl	BALTIMORE hplace (State or Foreign untry)
	Usual Residence of Decedent  10a. State 10b. Count		10c. City, Town or Lo	cation		5/26/19	10	VA  10d. Inside City Limits
death with the Maryland ms 23a or 28a-f show Invest be recilified at	MD BALT	IMORE	GLEN ARM	-				1 ☐ Yes 2 No
with the north of the recognition of the recognitio	10e. Street and Number	001107		10f. Zip Code		10	g. Citizen of What Co	untry?
0036 hours after death with the Maural, or items 23a or 28a-fs at Examiner must be rictilised by Funeral Directo	11. Marital Status  1 Never Married 2 Mar 3 Widowed 4 Divorce	12. Was Decedent Armed Forcas?  1 Tipes 2 In Yes, Give	Al-	21057 Vas Decedent of Pryes, specify Cub	Hispanic Origin? (Spec an, Mexican, Puerto R Specity:	ofy Yes or No- ican, etc.)	U.S.A.  14. Race - Ame Black, White Specify: WH	
15-0036 172 hours aft "natural; or		Year or Dates:	16a. Deced	lent's Usual Occup	pation	11	6b. Kind of Business/	Industry
21215-0 led within 72 ho yglene. ner than "natur it, the Medical. Completed	(Specify only high Elementary/Secondary (0-12)	College (1-4or	(Give life. L	kind of work done DO NOT use retire MAKER	during most of workin	9	OWN HOME	·
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after de Health and Mental Hyglene. Itam 27 is markad other than "natural", or items other traumatic event, the Medical Examinar of De Be Completed by Fune	17. Father's Name (First, Middle	, Last)	AMST	ER	18. Mother's Name		aiden Sumame)  BECKY	Stein
Mary and 2 sho halth and 1 n 27 is ma ar traums	19a. Informant's Name/Relation  E. LEE ROBBINS		4405	STARVIEW	and Number or Rural		-	(ip Code)
Baltimore, permit. Pages 1 ar Department of Hea mportant: If itam any injury or otha pace.	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (		20b. Place of Dispo cemetery, cren BALTIMORE				0c. Location - City or T	
Baltimore, permit. Pages 1 an permit. Pages 1 an permit of Heali Important: If item 2 any injury or other sonce.	21. Signature of Funeral Service		22	. Name and Addre	ess of Facility SOL ERSTOWN RO	LEVINSO	N & BROS.,	INC.
Pnysician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	a	d the death. Do not enterne.  a consequence of):	a staffed	ng, such as cardiac or	1000	st,	Approximate Interval Between Onset and Death
Sox 68760,	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):					
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ecords, P.O. B law requires that the dea as been signed by the att 2 should be detached to	(35 NOE 52/	ions contributing to death t	out not resulting to the un	nderlying cause gr	ven in Part I.		acco use contribute to	the cause of death?
The The page						24a. Was an autopsy perform	24b. Were au prior to death?	topsy findings available completion of cause of
of Vita Physician: this certific ral director, To Be (	25. Was case referred to medic examiner?			0.4	26. Place of Death			
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Divisio  To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi		ing Physician: To the best	of examination and/or inv	occurred at the ti	me, date and place, ar opinion, death occurre	nd due to the cau	use(s) and manner as te and place, and due	stated. to the cause(s)
To the within 2 To the complet	29b. Signature and the of certification	and manner st	AD	29c. Licens	se number	296	d. Date signed (Month	
3	30. Name and address of person EDDIE NAKHUDA		death (Item 23a) (Type,  DULANEY VA		D TIMONIU	M, MD 2.	1093	
State Registrar	31. Date filed (Month Ban Ya	TENTE E	rar's Signature					

Registrar

6:00 AM

DECEMBER 6, 2004

DEANE ROBBINS

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month DEC. Day **Physician** Young Ae Roh 3, 2004 8:00 РΜ /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Harborside Health Care Prince Georges Bowie If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2√2 F Director 229-21-0535 72 July 5, 1932 Korea Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f ehow other traumatic event, the Medical Examiner must be notified at MD Prince Georges Greenbelt 1 ☐ Yes 2√☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö or Iteme 23a 7756 Mandan Road 20770 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Merital Hygiene. Important: If item 27 is marked other than "natural", or Iten any injury or other traumatic event, the Madical Examinations. 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Asian δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 Banquet Server Hotel Banquet 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Woo Suk Kim Jung Ga Yoon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7756 Mandan Road, Greenbelt, MD Won Roh - Son 20770 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Park 12/6/2004 \* 4 ☐ Donation 5 ☐ Other (Specify) Elkridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21075 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 6 Day DIDAR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner the burial-transit certificate be executed the attending physicien and Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical use as 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Day be detached for Month Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 XNo 9 Unknown 9 Hlnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed/ Yes 2/2/No 2 🗌 No 1 🗌 Yes 1 ☐ Yes Division of Vital or Attending Physician: after death. Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and titlerof certifier 45660 occio MD De 7/1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CALLA d 31. Date filed (Moder, Cay, 1/el) 2004 Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiena For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 22:57 PM **Physician** KOGALSKI 07,2004 OPHIE DECEMBER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A John Hopkins Bayview Medical Center Baltimore 8. Dete of Birth (Month, Day, Yea Nov. 3, 1 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Min. Days Hours 1 M 2 XF 217 14 9496 81 1923 Maryland Director Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 77 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exacilities triust be notified at 10b. County 1 ☐ Yes 2 X No Maryland Anne Arundel Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 4 Wallace Avenue 21225 U.S. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: þ 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ould be filed withing d Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Clerical Social Security 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Vincent Lebuda Stella Rokicki and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) tof Health Anthony Rogalski Son 321 Farwell Road Chestertown, Maryland 21620 rother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 28urial 2 Cremation 3 Removal from State permit. Page Department of Important: if any injury or injury or 12/11/2004 | Baltimore, Maryland Holy Cross Cemetery 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. Frameworks erme 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 2 WEEKS **Physician** -UCMINANT disease or condition resulting in death) /Medical Due to (or as a consequence of) RENAL Examiner 2 WEEKS TE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine -transit certificate be executed and Due to (or as a consequence of): as the burial Box 68760, the attending physician Physician/Medical IF FEMALE esn If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Day Year for Month 5 Other (specify) detached of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown cate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2.20 No el or Attending Physicien: 1 s after death. If Director: After this certifical od in by the funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Yes 2 No 1 Enpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 T Homicide fo the he.
within 24 hours.
To the Funeral Di 29a. Certifier 1 Decertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number ZES - 000 DECEMBER 07, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTMORE, MD 21287 AMAR WOLFE STREET KRISHNASWAMY 600 NOCTH 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

0/3	08		For Unpend Iter	State of							ental Hy			201	70
			Registrar  1. Decedent's Name (First, Middle			Ce	піпсат	e or t	Deam		2. Date of Dea			3. Time	of Death
	Physicia /Medic		HELEN G. SEW	ARD				November 12, 2004						РМ	
	Examin		4a. Facility Name (If not institution,	give street and num	nber)				Location o			4c. (	County of De		
1				Hospital	7 1 - //	to a to bright about		Balt 1 Year	Imore		Data of Rid			/A	
10	Funeral Director	- 1	5. Social Security Number 217 24 1892	6. Sex 1 ☐ M 2 F	7. Age (In yrs. <b>77</b>	Yrs.	Months	Days	Hours	Min.	B. Date of Birt (Month, Da JAN - 3 (	y y ar)	27 MA	inthplace (State Country) RYLANI	or Foreign
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	the M.	ecto	MD . N/	A	DA			Code				10a. Citiz	zen of What	Country?	
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036	hours after urat', or Ite	l by F	3 Widowed 4 □ Divorced	If Yes, Giv Year or Da	ates:		1 🗌 Yes	2 <b>X</b> No	Specify:				Specify: I	BLACK	
15-0	72 hours "natural", Jical Exa	ietec	15. Decedent (Specify only highes	's Education t grade completed)		(Give	dent's Usu kind of wo DO NOT u	rk done d	during mos	t of working	9	16b. Kir	nd of Busines	ss/Industry	
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Maryland 21215-0036	ould be filed within 72 hours after death with the Maryla Mental Hygiens arked other than "naturat" or items 23a or 28a-1 shov atic event, the Madical Exerciter must be natified at	Be	17. Father's Name (First, Middle, I	DECEASEI	D)				18. Mothe		(First, Middle, KNOWN	Maiden	Sumame)		
aryk	S D E E	은	19a. Informant's Name/Relations	nip (Type, Print)		19b. Maili	ng Address	s (Street	and Numbe	er or Aural	Route Numbe	er, City or	Town, State	, Zip Cod 2 1	1215
e,	and 2 Health a sm 27 Is		EILEEN ZANTI  20a, Method of Disposition	(FRIEND		3537 Place of Disp					AVENU:			MORE, M.	υ <b>.</b>
mor	Pages lent of H nt: If ite ry or of		1 Burial 2 ☐ Cremation  1 ☐ Donation 5 ☐ Other (S)	3 □Removal from :		cemetery, cre	matory`or o	other plac	(θ)					le, MD	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 lis any injury or other trai		21. Signature of Fyner Service		wehn		2. Name ar ewis 517 F	T. G	ss of Facility Wynn Heigh	Funer	ral Hor	ne Balto	o. Md	21215-	6393
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that conly one cause on e	ause the deat	h. Do not en	ter the mod	de of dryin	ng, such as	cardiac or	respiratory a	rrest,		Approxim Interval B	ate etween
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S, P	ss tha gned se de		Part II. Other significant condition	ons contributing to de	eath but not res	sulting in the	underlying (	cause giv	en in Part I	1.				to the cause o	
<u>ين</u>	w require been sig	eted									24a. Was			autopsy finding	
Vital Reco	The lav te has	Completed									auto			to completion of ?	
ital	yaician: The is certificate ha director, page	Be C	25. Was case referred to medical examiner?							e of Death	(Check only	опе)			
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on o	fing F	tion:	27. Manner of Death  1 □ Natural 5 □ Pendir 2 □ Accident investi		h Day Year)	Foud Foud	at M	28c. Injur Wor 1 □	nyat nk? Yes 2.¶X∏		og. Describe	now injury	y occurred	u	ınk
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ā	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifyir	o Physician: To the	at res	owledge dea	th occurred	d at the tir	me, date ar	And place, a	nd due to the	cause(s)	and manner	as stated.	<u> </u>
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	To With	~	29b. Signature and title of certifie	11/10	10	2,	23	ic. cideris	OCME					13, 20	
			30. Name and address of person	who completed caus	se of death (Ite									·	
			31. Date filed (Month, Day, Year)	30 F	Registrar's Sign		Penn	Str	eet,	Balti	more,	Mary	land 2	21201	
	St Regist	ate rar	DEC 1	0 2004	Bener		4	por	KN						

			For State Registrar	State of	Maryland / De	partment <i>ertificate</i>			-	giene Reg. No. (	004	39174
	Physici /Media		Decedent's Name (First, Middle, L     THELMA A. SAV	*					2. Date of Dea		, 2004	3. Time of Death 8:45
	Examir		4a. Facility Name (If not institution, g. 1309 Roundhill R		ber)	4b. City, 1 Balti	own, or Locati	ion of Death			ounty of Death	1
	Funeral Director				. Age (In yrs. last birtho	(ay) If Under			8. Date of Birt (Month, Day 7/22/19	h y, Ye <i>ar)</i>	9. Birth	nplace (State or Foreign untry) HINGTON DC
yiand	now In		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o				// 22/ 1/		WASI	10d. Inside City Limits
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Maryland 21215-0036	ital Hygiene. Id other then "natural", event, I've Modical Exi	Completed	15. Decedent's I (Specify only highest g Elementary/Secondary (0-12) 12TH GRADE	Education rade completed) College (1-4	(G lin	ecedent's Usual live kind of work e. DO NOT use	done during r retired)	nost of workin	ng		of Business/li	
D ==	Hygi other ent, I		17. Father's Name (First, Middle, Las	st)	ADI	TINTSILL		other's Name	(First, Middle,		RAL GOV umame)	/ • 1
rylan	nd Mental Hygiene. marked other then imatic event, I've M.	To Be	PERCY P. SAWYER  19a. Informant's Name/Relationship	(Type Print)	19h M	ailing Address	Street and Nu		MA BACK		Cours State 7	in Code)
	G 00 3		PATRICIA A. DALTO			9 TURKE			WESTMIN			2 <b>11</b> 58
Page J	ient of Health and: If item 27 I		20a. Method of Disposition 1   Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Spec		20b. Place of Di cemetery,		e of ner place)	D	ate 3/2004	20c. Loca	tion - City or T	
Balti permit.	Department of Important: If i any injury or conce.		21. Signature of Funeral Service Lic	Colone	n	22. Name and 8521 LC				ON FUN ISON,		HOME, P.A.
38760, cate be executed	iate be executed /Medical Examiner und physician and the burial-transit	edicai Exam	23a. Part1 Enter the disease or corshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Di to (o	r as a consequence of): r as a consequence of): r as a consequence of):	enti	) (a	+	aseulo		Vian	Approximate Interval Between Onset and Death
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rds, P	been signed I should be det	by	Part II. Other significant conditions	contributing to dea	th but not resulting in th	e underlying car	use given in Pa	art I.	23e. Did to	~	p.	the cause of death?
I Rec	certificate has be rector, page 2 sho	Completed							24a. Was a autop: perfor	an 2 sy med? 2 No	24b. Were auto prior to co death? 1 \( \sum \text{Yes}	opsy findings available ompletion of cause of
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of Puy	nn. r. After this e funeral di	ation: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of (Month,	patient 2 ☐ ER/Outpa Injury 28b. Tim Day Year) Injur		c. Injury at Work?	2	ne 5 Reside 8d. Describe h			<sub>fy)</sub> scene
- b	s after death. II Director: A od in by the fu	Certification:	3 Suicide 6 Could not determined	be d 28e. Place o building	f Injury - At home, farm, , etc. <i>(Specify)</i>	street, factory,	office	2	8f. Location (S. City or Town		lumber or Run	al Route Number,
De Hospital	within 24 hours after of To the Funeral Direct completely filled in by	edical (	29a. Certifier (Check only one)  1 Certifying P 2 Medicel Exa	hysicien: To the base and manne	est of my knowledge, dis of examination and/o	eath occurred at r investigation, i	the time, date n my opinion, o	and place, and death occurre	nd due to the c d at the time, d	ause(s) an late and pla	d manner as s ace, and due t	stated. o the cause(s)
Tot	To t comj	Σ	29b. Signature and title of certifier	Aux			License numbe	er			igned (Month,	
	15		30. Name and address of person who	completed cause	of death (Item 23a) (Ty		CME		D	ecemb	er 7, 1	2004
	,		S. V. HOGAN 111		et Baltimo pistrar's Signature	re, MD	21201					
	Sta Registr	2	DEO T. 0.5004	Liena	- Congristion	don 1	J					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 004 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** SAFFRAN ALBERT Vaith 12-05 17=19 -2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** HARFORD OPPER CHESAPERICE MEDICAL CENTER BELAIN If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth Month, Day, 9. Birthplace (State or Foreign Number 7. Age (In yrs. last birthday) M 2□ F 2705 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral, or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ev Armed Forces? 1 Yes 2 No 11. Marital Status 2 Married 1 Never Married 27 No Baltimore, Maryland 21215-0036 ð 3 ☐ Widowed 4 ☐ Divorced "natural" er than "nature Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 10 other 18. Mother's Name (First, Middle, Maiden Sumame) Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic event <u>once.</u> Be Krimme brothu Qa. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1805 Jarrettsville MD 21084 attran-wite 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 Removal from State Air Momorial Gar. ' 4 ☐ Donation 5 ☐ Other (Specify) 9-04 21. Signature of Funeral Service L 22. Name and Address of Facility PORT DR. FOREST HILL, EVANS FUNCEAUCHAPEL-BEL Kotta 23a. Part1. Enter the disease, or complice shock, or heart failure. List only one the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure.

Immediate Cause (Final disease or condition resulting in death) **Physician** ASCUD /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) the hed i ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔁 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 1 Yes 2 No 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 es 2 No 1 🗍 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: affran, To the Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident **Director**: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I

completely filled Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1 21809 OME MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIMONIUM

State

Registrar

NAB

31. Date filed (Month, Day, Year)

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DEC 1 0 2004

YO NIC

2336

32. Registrar's Signature

			1 _ State	State of Maryland / Dep	partment of Health and Nertificate of Death		2004 391/0
	Physicia	an	1. Decedent's Name (First, Middle, Last)	Alla Hanne	Sc.	2. Date of Death Month D	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, or Location of Death	DECEMBER 4	R 8, 2004 12:30F <sup>M</sup> lc. County of Death
	*,		Saint Joseph 1  5. Social Security Number 6. Sex	Medical Center  7. Age (In yrs. last birthday	TOWS  If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Baltimore  9. Birthplace (State or Foreign
l.	Funeral Director		212-26-6524	M 2□F 77 Yrs.	Months Days Hours Min.	Month, Day, Yea July 26, 1	927 Baltimore, MD.
	iryland show		Usual Residence of Decedent  10a. State  10b. County	More Co. 10c. City, Town or L	ocation		10d. Inside City Limits
	r 28a-f s	Funeral Director	10e. Street and Number	will a	10f. Zip Code	10g. C	1 ☐ Yes 2 ÂŢÑo
	sath with	erai D	613 E. Rocky 1	4ill Road	2//52	and Man and Na	U.S.A.
036	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Heath and Mental Hygiene. Department of Heath 27 is marked other than "neturel", or items 23e or 28e-f show any Injury or other treumetic event, the Madical Examina must be mailthed at once.	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes ② No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecity Yes of No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	in 72 ho n "netur	Completed	15. Decedent's Educ (Specify only highest grade	completed) (Give	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	ing	Kind of Business/Industry
212	led with lygiene. her than	Com	Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)	College (1-4or 5+)	Truck Driver		Trucking
	should be find Mental Hamarked of	To Be	Harry Caspe	er Stengel	Inez	e (First, Middle, Maide , Kathe	erine Cordie
	and 2 sho ealth and ! n 27 is me		19a. Informant's Name/Relationship (Typ. Mrs. Patricia Jai	ne Stenger 613	ling Address (Street and Number or Run E. FOCKY Hil	1 Rd. 5	parks, MD, 21152
imore	Pages 1 ment of He ent: If iter ury or oth		20a. Method of Disposition  12 Burial 2 □ Cremation 3 □ Re  4 □ Donation 5 □ Other (Specify)	emoval from State 20b. Place of Dispersion o	position (Name of emalory or other place)	Date 20c.	Location - City or Town, State
Ball	permit. Departr Importe any Inju		21. Signature of Funeral Service License	· gan Se.	Name and Address of Facility  CACCAL ATTEM  7.3.25 DEK RA	011	ineral+Cremation(tr.
l,				cations that caused the death. Do not er	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
	/Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):	LEUKEMIA		3 WEFKS
	Examiner	-e	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):			
1	ecuted and -transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a consequence of):			
8760,	icate be executed physician and the burial-transit	dicai E	d	Due to (or as a consequence or).			
		n/Med	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregnancy			23d. Date of delivery
o O	that the death certifi ed by the attending I detached for use as	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□ Ectopic pregnancy □ Other (specify)		Month Day Year
rds, P	The law requires that the death certifi tte has been signed by the attending I aage 2 should be detached for use as	þ	Part II. Other significant conditions con	ributing to death but not resulting in the	underlying cause given in Part I.		ouse contribute to the cause of death?
		Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 No
	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ♣ No	ospital: 1 7 Inpatient 2 🗍 ER/Outpatie	Othor	h (Check only one)	6 □Other (Specify)
	ding Phys h. After this funeral di	tion: T	27. Manner of Death  1 Natural 5 Pending	28a. ate of Injury (Month, Day Year) 28b. Time ( Injury)	of 28c, Injury at	28d. Describe how inj	
Division	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification:	Z Accident investigation  3 □ Suicide 6 □ Could not be  4 □ Homicide determined	28e. Place of Injury - At home, farm, sibuilding, etc. (Specify)		28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by		29a. Certifier  (Check on 2 Medicel Exemin	icien: To the best of my knowledge, dea er: On the basis of examination and/or in	th occurred at the time, date and place,	and due to the cause(	s) and manner as stated.
	ro the H vithin 24 ro the F complete	Medicai	29b. Signature and title of certifier	and manner stated.	29c. License number		ate signed (Month, Day, Year)
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	0		30. Name and address of person who could be seen to be seen and address of person who could be seen and address of person address of person and address of person and address of person ad	mpleted cause of death (Item 26a) (Type		MARVI AMB	01004

		-	For State Registrar	State of Marylan	d / Depa <i>Cer</i>	artme <i>tifica</i>	nt of He	ealth and Death		Reg.		) 4	39177
	Diam'r to t		1. Decedent's Name (First, Middle, Last,	)					2. Date Mont	of Death h	Day Y	'ear	3. Time of Death
	Physicia /Medic		Joginder	Singh	Sarai					mber	7, 200		9:30 P <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. Cit		Location of Dea	th		4c. County of		
			3510 Susquehanna I				Belts						George's
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs.			ler 1 Year s Days	If Under 24 Hrs Hours Min	. (Mon	th, Day, Yo	ear)	D. Birthp Cour	
	Director		577-64-5509	76	Yrs.				Marc	ch 1,	1928		India
	pur *	-	Usuel Residence of Decedent  10a, State 10b. County	10c. Cit	y, Town or Lo	cation						1	0d. Inside City Limits
	aryla sho	2											1 ☐ Yes 2 No
	Ne N	ecte	Maryland Prince (	George's	Ве		7 <u>ille</u> Zip Code			100	. Citizen of Wh	at Cour	ntry?
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	8 23s	rai	3510 Susquehanna I	)rive 12. Was Decedent Ever in U.	S 13 1	Nas Dao	207		Specify Yes		14. Race		
	er de Itam	nue	11. Marital Status  1 ☐ Never Married 2 ☐ Married	Armed Forces?	.3.	f Yes, sp	ecify Cubar	panic Origin? ( , Mexican, Pue	rto Rican, et	c.)		White,	
36	s aft	by F	3 ₩ Widowed 4 Divorced	If Yes, Give Year or Dates:		1 🗌 Yes	2 <b>X</b> ) No	Specify:			Specify:	Δ	sian
Ş	hour tural	pa	15. Decedent's Edu		16a, Dece	dent's Us	sual Occupa	tion		16	b. Kind of Busi		
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2	withi ene.	Щ	Elementary/Secondary (0-12) 12th	College (1-4or 5+)	D-	inlo	matic	Assista	ınt		India	Emb	assy
9	filed Hygi ther ant,		17. Father's Name (First, Middle, Last)			F = -		18. Mother's Na		Aiddle, Ma	iden Sumame,		
Baltimore, Maryland 21215-0036	d be antal	To Be	Jagat Singh	Sarai				Harna	.m	Kaur			
2	mari mati	F	19a. Informant's Name/Relationship (T)		19b. Mailir	ng Addre	ss (Street a	nd Number or F	Rural Route	Number, C	ity or Town, Si	ate, Zip	Code)
<u>8</u>	d 2 s th ar 27 is trau		Igbal Sarai/ Son		5752	Whi	stling	Winds	Walk	Clar	ksville	e, M	D 21029
ē,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hyglene. Important: If tem 27 is marked other than "natural, or items 23a or 28a-f show any follury or other traumatic event, it a Medical Examinar must be modified at ance.		20a. Method of Disposition	20b. P	lace of Dispo	sition (A	lame of		Date	20	c. Location - C	ity or To	own, Slate
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	/Medical Examiner		Todaking in doday)	Due to (or as a conseq									**
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Вох	ath c	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	Ideath 3	Ectopic Other	pregnancy				Mont		Day Year
o O	the the	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	ioatii J	3 011101	(Specify)						
P.O.	that the ed by detac		Part II. Other significant conditions of	ontributing to death but not res	sulting in the u	nderlyin	g cause give	n in Part I.	23e	. Did toba	cco use contrib	ute to t	he cause of death?
Division of Vital Records,	signe signe	l by		•			•			1 🗌 Yes	2 <b>√</b> □ No 3	☐ Prot	ably 4 Unknown
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ec	e law has b	ldu							248	. Was an autopsy performe	d? pri	or to co	psy findings available mpletion of cause of
=	cate pag	S							10	Yes 2	No 1[	Yes	2 No
/its	Physiclan: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		_	Othe	26. Place of D			-		
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sio	Attanding or death.	cati	2 Accident investigation 3 Suicide 6 Could not be			M		/es 2 □ No	29t   000	tion /Stra	et and Number	or Rue	al Route Number,
Ξ	after d Direct Jin by	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, rarm, st fy)	reet, tac	lory, office			or Town,		Or Fibre	i riodia i validar,
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	Hospital     24 hours a     Funeral D     intely filled i	edical	(Check only 2 Medical Exam	ysician: To the best of my knowner: On the basis of examination	owledge, deat ation and/or in	n occurr vestigat	ed at the tim ion, in my op	ie, date and pla- pinion, death oc	ce, and due curred al the	time, date	se(s) and man e and place, ar	d due t	the cause(s)
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	To To	-	29b. Signature and title of certifier	5			D289				Decembe		
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	20		30. Name and address of person who					OBMIN OF	907 C. A1	5294	2005	12:42	
			Pritam S. Saini,	M.D. 9101 Ch 32. Registrar's Sign	erry_L	ane,	Suit	211 1	Laurel	, Mai	ryland	2070	)8
	St Regist	ate rar	31. Date filed (Month, Day, Year)	2004 Paras		6	los	. 1/2/					
	101	4.7.4		( ) (1 1 1 1 1 ) Last ( )		Theff	161 186	- K - A - I					

ORIGINAL

Bruce M. Serio 04-7894 AKG

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	_ FOI	artment of Health and Mental Hygier rtificate of Death	2001, 20170
Physician	1. Decedent's Name (First, Middle, Last)  Michael Bruce Serio	2. Date of Death Month December	3. Time of Death 7, 2004 11:42 A <sup>M</sup>
/Medical Examiner	4a. Facility Name (If not institution, give street and number)  2 Oak Grove Avenue	4b. City, Town, or Location of Death	4c. County of Death Baltimore County
Funeral Director	5. Social Security Number Unk 6. Sex  **XXM 2 \subseteq F  **Security Number Unk  T. Age (In yrs. last birthday)  **Security Number Unk  **Total Security Number Unk  The security Num  The security Number Unk  The security Number Unk  The security	Months Days Hours Min. (Month, Day, Yea	9. Birthplace (State or Foreign Country) 948 Maryland
D D	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L		10d. Inside City Limits
vith the Mar to r 28a-f st be natified Director	Maryland Baltimore Arbutus  10e. Street and Number		Citizen of What Country?
er death v	1225 Greystone Road  11. Marital Status  XXNever Married 2□ Married  12. Was Decedent Ever in U.S. Armed Forces?  XXYNever Married 2□ Married  12. Was Decedent Ever in U.S. Armed Forces?	21227 of  Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	America  14. Race - American Indian, Black, White, etc.
72 hours at natural; or lical Exem-	3 Widowed 4 Divorced Yes, Give Year or Dates: Korea  15. Decedent's Education (Give Completed)  (Specify only highest grade completed)	e kind of work done during most of working	Specify: White Kind of Business/Industry
d 2 should be filed within 72 hours aft the and Mental Hyglene. 27 is marked other than "natural", or traumatic avant, the Medical Exertitranmatic Be Completed by F	Elementary/Secondary (0-12) College (1-4or 5+) 2 Ca	DO NOT use retired)  rpenter	Building
should be fill and Mental His markad ott umatic avan	17. Father's Name (First, Middle, Last)  George Serio	18. Mother's Name (First, Middle, Maid  Diana Doris Madden	
and 2 sh aaith and m 27 is m har traum	Kathleen M. Lemmer (Sister) 601	ing Address (Street and Number or Rural Route Number, City  Zawl Court; Annapolis, Mary osition (Name of Date 200	land 21401
Page nent o ant: If ury or	* UDonation 5 Other (Specify) Loudon Pa	matory or other place) Dec. 14, ark Cemetery 2004 Ba	ltimore, Maryland
parmit. Departr Importa any inj.	233 Rada Enter the disease, or complications that caused the death. Do not ex	2. Name and Address of FacilityLoud on Park F 3620 Wilkens Baltimore, Ma	ryland 21229 Approximate
Physician /Medical	shock, or heart failure. List only one cause on each line.  Imbediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic Condition Due to (or as a consequence of):	rdiovascular disease	Interval Between Onset and Death
Examiner 50 U.S.	Sequentially list conditions, Pary leading to immediate cause. Enter Underlying Cause (Disease or injury		
cate be executed physician and the burial-transit dical Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):		
Attanding Physician: The law requires that the death certificat death.  death.  sctor: After this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as the figure of the second period of the second filter		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
w requires that been signed b should be deta	Part II. Other significant conditions contributing to death but not resulting in the	, g g	o use contribute to the cause of death?  2 □ No 3 □ Probably 4 ሺ Unknown
The law required that been so page 2 should		24a. Was an autopsy performed 1 114 Yes 2 🗆	
To the Hospital or Attanding Physician: The law requires the within 24 hours after death.  To the Funaral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be a Medical Certification; To Be Completed by	25. Was case referred to medical examiner?  **XX*Yes 2 No	of 28c. Injury at 28d. Describe how in Work?	Mar (Specify at scene
To the Hospital or Attending Physically within 24 hours after death.  To the Funeral Director: After this of completely filled in by the funeral director.  Medical Certification; To	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	M 1 □ Yes 2 □ No  treet, factory, office 28f. Location (Street City or Town, Str	and Number or Rural Route Number, ate)
To the Hospital or within 24 hours after to the Funeral Dir completely filled in Medical Cert	29a. Certifier (Check only one)  1□ Certifying Physician: To the best of my knowledge, deal one)  2 ☑ Medical Examiner: On the basis of examination and/or and manner stated.	nvestigation, in my opinion, death occurred at the time, date a	and place, and due to the cause(s)
Total within compare compare MA	29b. Signature and title of certifier  M. W. W		Date signed (Month, Day, Year) ember 8, 2004
211	30. Name and address of person who completed cause of death (Item 23a) (Type LING LI MID	111 Penn Street, Baltimore	, Maryland, 21201
State Registrar	31. Date filed (Month, Day, Year)  DEC 1 0 2004  32. Registrar's Signature	South !	

			State of Maryland / Dei	partment of Health and Mental Hygi					
			1- State Registrar	ertificate of Death Re	9.N2004 39179				
ı	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year				
	/Medic	al	Dorothy Lane Steenerson	December	7 2004 1:05P M				
	Examin	er	4a. Facility Name (If not institution, give street and number)  Vantage House	4b. City, Town, or Location of Death	Howard				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Columbia  y) If Under 1 Year   If Under 24 Hrs.   8. Date of Birth	9. Birthplace (State or Foreign				
	Director		577-26-3837 1□ M 2区F 88 Yrs.	Months Days Hours Min. (Month, Day, May 17,	1916 Illinois				
	pue *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location	10d. Inside City Limits				
	f sho	ō		cott City	1 ☐ Yes 21x No				
	7 28e	Director	10e. Street and Number		Dg. Citizen of What Country?				
	be filed within 72 hours after death with the Maryland stal Hygiene. Set other than "natural", or iteme 23e or 28e-f show event, the Modinal Exp. direct rust be notified at		5400 Vantage Point Road	21044	U.S.A.				
	eme .	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.				
36	or it	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💆 No	1 ☐ Yes 2 ☑ No Specify:	Specify:				
Ö	hour:		3 ☑ Widowed 4 ☐ Divorced Year or Dates:  15. Decedent's Education 16a. Det	cedent's Usual Occupation	White 16b. Kind of Business/Industry				
15	in 72 n "nat	Completed	(Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of working a. DO NOT use retired)	ob. Ring of businessmanstry				
212	e filed within al Hygiene. other than " vent, Ine Mas	mo	Elementary/Secondary (0-12) College (1-4or 5+)	ıblic Relations	Sales				
pu	be filed tal Hygid d other event, II	Bec	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, M	faiden Sumame)				
yla	should be and Menta marked umatic ev	10	Henry Clay Lane	Ida Divine					
Maryland 21215-0036	0 0 = 0			ailing Address (Street and Number or Rural Route Number,					
	s 1 and f Health item 27 other tr			32 Goodin Circle Columbia, sposition (Name of rematory or other place)  Date	MD 21046 20c. Location - City or Town, State				
nor	9 = 5		1 La Burial 2 Cremation 3 Memoval from State						
Baltimore,	그 된 원 등	. :	21. Signature of Final Service Lightsee	22. Name and Address of Facility	Columbia, Maryland				
B	Depa Impo any i	li i	M01290	Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Colu	mbia. Maryland 21045				
			23a. Part1. Enter he disease, or complications that caused the death. Do not eshock, or heart failure. List only one cause on each line.		st, Approximate Interval Between				
П	Pnysician		Immediate Cause (Final disease or condition	Onset and Death					
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	1 1 1					
ľ	Lxammer	ڀ	Sequentially list conditions, b. Cerebrey	Vascular Accid	ent				
	ted nsit	Sequentially list conditions, if any, is admig to minimize a cause. Enter Underlying Cause (Disease or injury							
	e be executed /sician and e burial-transit	Examiner	that initiated events c. resulting in death) Last Due to (o as a conseque ce of):	Col.					
760,		cail	d. Colouran	arten Diseigs	0				
68	death certificate be executed e attending physician and of for use as the burial-transit	Medi	ICCCMAIC.	(					
Вох	th cer tendii or use	hysician/Med	IFFEMALE: 23b. Was decedent pregnant in the past 12 months?  1 □ Live birth 2 □ Fetal death	3 □Ectopic pregnancy	23d. Date of delivery  Month Day Year				
о. В	D 00 D	/sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	5 Other (specify)	Month Day Feat				
<u>α</u>	that the d ed by the detached	Δ.	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I. 23e. Did tob	acco use contribute to the cause of death?				
Records,	Se LE e	d by	Donnertic		s 2 No 3 Probably 4 Monknown				
COL	w require been signature	Completed	con coletantino	March Om Deport 24a. Was ar	24b. Were autopsy findings available				
Re	o = 2	omp	11 6400 01 01 0000	autops) perform  1 yes 2	prior to completion of cause of death?				
Vital	icien: Th certificate rector, pag	Be C	25. Was case referred to inedical	26. Place of Death (Check only one					
of V	d is	To	examiner?  1   Yes   2   No	ient 3 DOA Other: 4 Nursing Home 5 Reside	nce 6 Other (Specify)				
ם	ding Ph th. After th funeral		27. Manne of Death 1 √atural 5 □ Pending 28a. Date of Injury (Month, Day Year) 1 √atural 1 □ Pending	y Work?	w injury occurred				
Sio	Attending r death. ector; After by the fune	icati	2 Accident investigation 3 Suicide 6 Could not be 280 Place of Injury - At home farm	M 1 Yes 2 No	eet and Number or Rural Route Number,				
Division	after of All	Certification:	4 Homicide  determined  28e. Place of Injury - At home, farm, building, etc. (Specify)	City or Town	State)				
_	To the Hospitel or Attenc within 24 hours after death To the Funerel Director; completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de	eath occurred at the time, date and place, and due to the ca	use(s) and manner as stated.				
	the Ho nin 24 h the Fu	edicai	(Check only one)  2 Medicel Exeminer: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurred at the time, da	te and place, and due to the cause(s)				
	vithir To the	1	29b. Signature and title of certifier	29c. License number 25	d. Date signed (Month, Day, Year)				
)	116		wares 2, and	D15425	12/9/04				
1	D1'		30. Name and address of person who comple ed cause o' deat (Item 23a) (Typ	pe, Print)	6.111- 110 21- 2				
7	<i>)</i>		31. Date filed (Month, Day, Year)  32. Registrar's Signature	monde He HU Eax	awville, all 4228				
	Sta Registi		DEC 1 0 2004 Beneva	4					
				Ana di					

		·	For State Registrar	State of N	Maryland / De <sub>l</sub>	partment of F ertificate of	lealth ar <i>Death</i>		giege 0 14	39180
ı	Physici	20	1. Decedent's Name (First, Middle, L	•				2. Date of Dea Month	ath Day Year	3. Time of Death
1	/Medic		Doris	Seibel				Decembe	r 3 2004	5:45P <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, g		er)	4b. City, Town, o		Death	4c. County of Deat	
			Manor Care Nursi 5. Social Security Number 6.		Age (In yrs. last birthda	Catons  If Under 1 Year		Hrs. 8. Date of Birth	Baltimo	
	Funeral Director		217-14-0610	1 M 2 1 F	82 Yrs.	Months Days		Min. (Month, Day	v, Year) Co	nplace (State or Foreign untry) yland
	D D		Usual Residence of Decedent					TIPLET .	12,1922 1141	J Lana
	anylar show	_	10a. State 10b. County		10c. City, Town or					10d. fnside City Limits 1 ☐ Yes 2 ☑ No
	he M	Director	Maryland Baltim	ore	Cat	onsville				
	with t		10e. Street and Number	1		10f. Zip Code			10g. Citizen of What Co	,
	leath	eral	302 Waveland Roa	12. Was Decede	nt Ever in U.S. 13	2122 Was Decedent of I		n? (Specify Yes or No-	U.S.A.	
ω	riter o	Funeral	1 ☐ Never Married 2 ☑ Married	Armed Force 1 ☐ Yes 2	s? © No			n? (Specify Yes or No- Puerto Rican, etc.)		e, etc.
93	within 72 hours after death with the Maryland one. then "neturel", or items 23e or 28e-f show the Madical Examples for neal the netitled at	b	3 Widowed 4 Divorced	If Yes, Give Year or Date	s:	1 ☐ Yes 2 🖾 No	Specify:		Specify: Wh	ite
5	72 h	Completed	15. Decedent's (Specify only highest g		16a. Dec (Gi	edent's Usual Occup e kind of work done DO NOT use retire	ation during most o	of working	16b. Kind of Business/	ndustry
121	within sne.	шb	Elementary/Secondary (0-12)	College (1-4d	or 5+)	DO NOT use retire ousewife	d)		Own Hon	10
2	be filed within 72 hours after death with the Marylan ital Hygiene. Id other then "neturel", or liems 23e or 28e-1 show event. Its Medical Examination mast be mailled at		17. Father's Name (First, Middle, Las	st)	110	Jusewile	18. Mother's	s Name (First, Middle,		10
an	ld be entai ked o	To Be	Herman Day	,				na Wyatt	,	
ary	2 should be filed v n and Menta! Hygie 'Is marked other t reumetic event. III	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Ma	ling Address (Street	and Number	or Rurai Route Numbe	r, City or Town, State, Z	Tip Code)
ž	and 2 alth a 127 ls		Thomas Seibel (	Son)	5 K	el Haul I	rive	Grasonvill	e, Maryland	1 21638
ore	of He of He fiterr		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	□ Bamayal from Sta	20b. Place of Dis	position (Name of ematory or other pla Memoria	ce)	Date	20c. Location - City or	Town, State
Ĕ	Pag ment ent: I ury o		'4 □Donation 5 □ Other (Spec		Park		12		Sykesville,	_
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If Item 27 Is marked any injury or other treumetic evone.		21. Signature Funeral Service Lie	ensee		22. Name and Addre Vitzke Fui 1630 Edmor	ess of Facility neral H ndson A	lome of Cat venue Cato	onsville, I	nc. ) 21228
			23a. Part1. Enter the disease, or co shock, or heart failure. List only	mplications that caus y one cause on each	sed the death. Do not e	nter the mode of dyi	ng, such as ca	ardiac or respiratory arr	rest,	Approximate Interval Between
F	Priysician		Immediate Cause (Final disease or condition	_ a	Metus	tatic (	lucin	ome		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequence of):					Corporation
		-	Sequentially list conditions,	b. — Due to for:	as a conse uence of					
	ited nsit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	200 (0 (3)	as a sonse grones of					
Ć,	execu n and ial-tra	Exai	that initiated events resulting in death) Last	c. Due to (or	as a consequence of);		<u>_</u>			
8760,	the death certificate be executed y the attending physicien and iched for use as the burial-transit	dlcal		d						
9	ntifica ng ph as th	Medi	IE EEUWE							_
Вох	eath certific attending p I for use as	lan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom 1☐Live birth		□Ectopic pregnanc	v		23d. Date of deli	*
O.	e dea the at ned fo	Physici	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4□Pregnant 9□Unknowr	at time of death 5	Other (specify)			Month	Day Year
P.O.	that the de ned by the a detached t		Part ff. Other significant conditions	contributing to death	but not resulting in the	underlying cause di	en in Part I	23e Did to	bacco use contribute to	the cause of death?
Records,	8 50	d by	CV	A		andonying ozobo gn	on arran.		es 2□No 3□Pro	
Sor	w require	ete	0.6	10				24a. Was a	24h Were au	topsy findings available
	The law ate has page 2 :	Completed						autops perfor	med? prior to c	ompletion of cause of
Vital		0	25. Was case referred to medical				26 Place of	1 ☐ Yes f Death (Check only on		2 🗋 No
	ys dii	ToB	examiner? 1 \( \text{Yes} \) 2 \( \text{No} \)	Hospital:	atient 2 ER/Outpati	ent 3 DOA Ott	-		ence 6 □Other (Spec	ifv)
0	Attending Physicien: r death. ector: After this certific by the funeral director,		27. Manner of Death  1 Natural 5 Pending	28a. Date of it	njury 28b. Time Day Year) Injury		y at	TO SERVICE STATE OF THE SERVIC	ow injury occurred	,
Sio	ottendir death. ctor: Af y the fur	atic	2 Accident investigati	on	, , , , , , , , , , , , , , , , , , , ,		Yes 2 □ No	)		
Division of	after death after death Director: ,	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	a 280. Place of	fn <del>j</del> ury - At home, farm, etc. <i>(Specify)</i>	street, factory, office		28f. Location (Si City or Town	treet and Number or Ru n, State)	ral Route Number,
	pitel v		29a. Certifier 1 Certifying F	husisis - T	at of our transition of	th annual and an		elega and division		
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical	(Check only 2 Medical Expone)	aminer: On the basis	s of examination and/or	investigation, in my	ppinion, death	occurred at the time, d	ause(s) and manner as late and place, and due	stated. to the cause(s)
	To t To tl comp	2	29b. Signature and title of certifie	MD		29c. Licens	se number		29d. Date signed (Month	
,	1/0			- u/		<i>D</i>	2750	54	1216/6	
	) 71		30. Name and address of person wh	Alther	nan 18	38 (	Seen	e Then K	12/6/69	208
	Sta Registr		31. Date filed (Month, Day, Year)  DEC 1 0	1	strar's Signature					

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of	Marylar		artmen rtificate			and M	lental Hyg	iene,		4 30	1121
			Decedent's Name (First, Middle, La	st)							2. Date of Deat	h			of Death
	Physic /Medi		Dorothy Duval Si	mmons							Month Decembe	r 3,	2004	r	
	Exami		4a. Facility Name (If not institution, giv		ber)		4b. City,	Town, or	Location o	of Death			County of De		- F
			Catonsville Comm	ons Nurs	ing Ho	ome			ille				Balt	imore	
	Funeral		5. Social Security Number 6. S	ex 7 □M 252 F		last birthday)	If Under Months	1 Year Days	If Under 2	24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)	9. B	irthplace (Stat	e or Foreign
	Director		215-10-8297 Usual Residence of Decedent		87	Yrs.					April 1	3, 1	.917 M	aryland	<u> </u>
	land ow		10a. State 10b. County		10c. Ci	ity, Town or Lo	cation							10d. Inside	City Limits
	Mary -f sh	ţō	Maryland Howard		E1	licott	City	,						1 🗆 Y	es 2 X No
	r 28e	rec	10e. Street and Number				10f. Zip	Code			1:	0g. Citiz	en of What (	Country?	
	h with	<u>e</u>	3252 B Normandy W	oods Dri	ve		2	1043				US	:A		
	ems ems	ner	11. Marital Status	12. Was Deced	ent Ever in U	J.S. 13.	Was Deced	tent of Hi	spanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)		4. Race - An	erican Indian,	
36	or it	by Funeral Director	1 Never Married 2 Married	1 ☐ Yes 2	₩ <sub>No</sub>		1 ☐ Yes 2		Specify:	, 1 46110	riioari, etc.)		Black, Wi Specify: W	hite	
8	urel',	D	3 XWidowed 4 □ Divorced	Year or Dat	es:										
21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or items 23e or 28e-f show the Modical Enaminat must be notified at	Completed	15. Decedent's E (Specify only highest gra	ducation ide completed)		16a. Deced		k done a	luring most	of worki	ing	16b. Kin	d of Busines	s/Industry	
12	withi ene. than	mc	Elementary/Secondary (0-12)	College (1-4	for 5+)		creta		/			F100	tric	Motor	
D	filed Hygi other ent,	BeC	17. Father's Name (First, Middle, Last			, 50	CICCA	L y	18. Mothe	r's Name	(First, Middle, A			1001	
an	lid be lental rked ic ev	To B	Conrad Heilman						Rhoda	. Swi	itzer				
Maryland	2 should be filed within hand Mental Hyglene. 7 is marked other than "raumatic event, the Mac		19a. Informant's Name/Relationship (	Type, Print)							l Route Number,				
	1 and 2 Health a tem 27 is		Henry McRobie			715	Ingle	side	Aver	nue;	Catonsv	ille	, MD	21228	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene. Important: If them 27 is marked other than "naturel", or items 23e or 28e-f show any injury or other traumatic event, It a Medical Examinar must be natified a once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Damoual from St	20b. F	Place of Dispo	sition (Nam	ne of ther place	9)	D	ate	20c. Loc	ation - City o	or Town, State	
Ē	Pages ment of I ant: If it ury or o		'4 □Donation 5 □ Other (Specif			lto-Wa	sh.Cr	emat	ory	12/1	3/2004	Laur	el. Ma	arvland	I
alt	permit. Departr Importa any inj		21. Signature of Funeral Service Licer	ISP0		22	Name and	d Addres	s of Eacility	n Sc	hwab Fu	nera	1 Hom	e. Inc.	
ш_	205 g g		Vester J.	tules			736 E	dmon	dson	Aver	nue; Cat	onsv	ille,	MD 212	228
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cau one cause on eac	used the deat ch line.	th. Do not ent	er the mode	e of dying	g, such as	cardiac o	r respiratory arre	st,		Approxim Interval B	etween
	Physician		Immediate Cause (Final disease or condition	a PA	JEU.	MON	IA							Onset an	d Death
	/Medical Examiner		resulting in death)	Due to (or	as a conseq	quence of):									1 2
		<u></u>	Sequentially list conditions,	b. Due to /or	as a conseq	tuonee of).									
	led	Examlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	IO) 01 <b>6</b> 00	as a conseq	querice or):								ļ.	
	al-trai	xar	that initiated events resulting in death) Last	c. Due to (or	as a conseq	juence of):									
8760,	The law requires that the death certificate be executed at the been signed by the attending physician and page 2 should be detached for use as the burial-transit	dlcal E		4											
687	ificate g phy as the	edlo		. U.											
ŏ	leath certific attending pl	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco								23	d. Date of d	elivery	
ω.	death e atte	lcla	in the past 12 months? 1 □ Yes 2 ☑ No	4□Pregnar	h 2∐Feta ntattime ofd		Ectopic pre   Other <i>(sp</i> e						Month	Day	Year
P.0	that the ded by the detached	hys	9 □ Unknown	9□ Unknow	m										
	es tha igned be de	by F	Part II. Other significant conditions of	ontributing to dea	th but not res	ulting in the ur	nderlying ca	ause give	n in Part I.		23e. Did tob	acco use	e contribute	to the cause of	f death?
ord	v requir been si should	ted					<del></del>				1 ☐ Ye	s 2 🗆	No 3□F	robably 4	nknown
Records,	e law r has be je 2 sh	Completed									24a. Was an autopsy	)	24b. Were a	utopsy finding completion of	s available
		Con									perform	ed? No	death? 1 ☐ Ye	n 1	04430 01
Vital	ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?						26. Place	of Death	(Check only one	)			
of \	shysi this c	P	1 ☐ Yes 2 No	Hospital: 1 ☐ Inp		ER/Outpatien			4 Sevur	sing Hon				ecify)	
n c	ding Ph h. After th funeral	lon	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of (Month,	Day Year)	28b. Time of Injury		Bc. Injury Work			28d. Describe hor	w injury	occurred		
Division	Attending Physician: er death. rector: After this certific by the funeral director,	Certification;	2 Accident investigation 3 Suicide 6 Could not b		Llainer At b	omo form et	M		′es 2□N	-	206 Lanation (Ct.	4	A 6		
Σ	l or Attendated after death	ertif	4 Homicide determined	building	, etc. (Specif	ome, farm, stre by)	et, ractory,	, onice		2	28f. Location (Str City or Town,		Number or F	turat Houte Nu	mber,
	ours ours nerel filled		29a. Certifier 1 Certifying Ph	vsician: To the b	est of my kno	wledge death	occurred a	at the time	e date and	I place a	and due to the ca	1100/0) 21	nd mannar a	n stated	
	24 h	Medical	(Check only 2 Medical Examone)	niner: On the bas and manne	is of examina	ition and/or inv	estigation,	in my op	inion, death	h occurre	ed at the time, da	te and p	lace, and du	e to the cause	(s)
	To the Hospital or within 24 hours after To the Funerel Dirt completely filled in I	Me	29b. Signature and title of certifier				29c.	License	number		29	d. Date	signed (Mor	th, Day, Year)	
	1	/	> NAHOR R		M.	1.	M	058	QT 2	7	17	ECF	MBER	7 1	200 A
1	Al		30. Name and address of person who	completed cause	of death (Iten	n 23a) (Type. I			T	,			יייטכוץ		T
2	P		MANA CEASAR	0 0 1	JORTH	EUTA		REE	T S'	TE -	308 BAT	TIM	NORE	MNZ	1207
	Sta		31. Date filed (Month, Day, Year)		istrar's Signa		0	1			/ ·		<u>-</u>		
	Registr	rar 1	DECTO	2004	Deper		1 1	loon	Kal						

			1 – For State Registrar				id / Depart	ment	of Health an of Death			2004	39182
	Physici	an	1. Decedent's Name (First, Mi						•	2. Date of D	Death Da	y Year	3. Time of Death
1	/Medi		Cherree Lynn							Decer	nbek	320c	110,0,
1	Examir	ner	4a. Facility Name (If not institu		•	1100		<u> </u>	wn, or Location of D		40	. County of Dea	th
			5. Social Security Number	6. Sex	TALTY	<u> </u>	PITAL  last birthday)	f Under 1	Year   If Under 24		ieth	O Pie	theless (Chate as Farrier
	Funeral Director		216-42-9676			60				Hrs. 8. Date of E Vin. (Month, I JUNE ]	ay, Year,	944 Ma	thplace (State or Foreign
			Usual Residence of Decedent		21					DOINE 1	.0, 1	944 Ma.	ryland
	yland		10a. State 10b. Cou	nty		10c. Cit	y, Town or Locat	ion					10d. Inside City Limits
	a Mar	ctor	MD			Bal	timore						1 X Yes 2 □ No
	th with the Marylar 23a or 28a-f show ust be notified at	Sire	10e. Street and Number					10f. Zip C	ode		10g. Ci	tizen of What Co	ountry?
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 Ie marked other then "naturel", or Items 23a or 28a-f show any injury or other traumatic event, I're Medical Examinational be notified at once.	la	1250 S. Gran						229		US	A	
	ar deg	une	11. Marital Status		12. Was Decedent Armed Forces?		.S. 13, Wa	s Deceder es, specify	t of Hispanic Origin Cuban, Mexican, P	? (Specify Yes or Nuerto Rican, etc.)	10-	14. Race - Ame Black, Whit	
36	s afte	Ϋ́F	1 ☐ Never Married 2 ☐ N  3 ☐ Widowed 4 ☐ Divord		1 ☐ Yes 2 ☐ If Yes, Give	No	1 🗆	Yes 2	No Specify:			Specify:	white
21215-0036	hour turel	pa p		ent's Educ	Year or Dates:		16a. Deceden	t'e Heual (	Occupation		16h K	and of Business	
5	in 72	let	(Specify only hig	hest grade	completed)		(Give kin	d of work	done during most of	working	100.1	and or business.	Middsily
12	there there	E O	Elementary/Secondary (0-1:	2)	College (1-4or 5	5+)		Iomem.				Own Home	2
	Hyg Hyg other ent,	O	17. Father's Name (First, Midd	le, Last)				<u>IOIII CII</u>		Name (First, Midd			
<u>a</u>	id be lental ked ic ev	O.B	James LeeRoy	Guthi	rie				Trma	Emily Wel	1 = 1,70	r+h	
Maryland	shound M	-	19a. Informant's Name/Relation				19b. Mailing A	Address (S	treet and Number o				Zip Code)
	nd 2 alth a 27 le		Dorothy A. Ba	rber	- daught	er	1250	S. G	rantley S	t., Balti	more	, MD 2	1229
ē	item othe		20a. Method of Disposition			20b. F	Place of Disposition	on (Name	of	Date	7	ocation - City or	
Ë	Page ient c int: If		1 ⊠Burial 2 □ Cremation 5 □ Other	n 3 ∐R∈ <i>(Specify)</i>	emoval from State		•	-	• Park 1	2/7/2004	El	kridge,	MD
Baltimore,	partition partit		21. Signature of Funera Sarv	ce License	18		22. N	ame and	Address of Facility	70	_		
Ö	Per la co		Mo	1/h			Gar 1725	y L. O Was	Kautman F	uneral Ho	ome (d	Meadowr MD	idge MP, Inc. 21075
			23a. Part1. Enter the disease shock, or heart failure. I	or complic	cations that caused	the deat	h. Do not enter t	he mode o	of dying, such as car	diac or respiratory	arrest,	,_,_	Approximate Interval Between
1	Physician	. 11	Immediate Cause (Final disease or condition	,		ardi			emias				Onset and Death
4	/Medical		resulting in death)	a a	Due to (or as			vrgnn	E 1110 3				73 7111162
	Examiner		Securation, list conditions	ь	A+1	nero s	clerche	hee	mt dis	eure			10 4+3
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	•	Due to (or as	a conseq	uence of):						
	nd ransi	Examiner	Cause (Disease or injury that initiated events	0			y ointe	mal	disease				1045
760,	ate be executed hysician and he burial-transit	Ĕ	resulting in death) Last		Due to (or as	a conseq	ylence of):						
876	ate b hysic the b	Ilcai		d				-					
68 ×	The law requires that the death certifica ate has been signed by the attending phoage 2 should be detached for use as th	Completed by Physiclan/Med	IF FEMALE:			,							
Box	ath co	lan/	23b. Was decedent pregnant in the past 12 months?	2	3c. If yes, outcome 1☐Live birth	2 Feta	l déath 3 ⊟Ec	topic preg			- 11	23d. Date of del Month	livery Day Year
0.	the a	/sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown		4□Pregnant at 9□Unknown	time of d	eath 5∐O	ther (spec	fy)				
9.	hat the deby detac	Ph	Part II. Other significant cond	litions con	tributing to death h	ut not res	ulting in the unde	rtvina cau	se given in Part I	23e Did	tobacco	use contribute to	the cause of death?
Records,	ires t signe	by	Diobetes.	150h	amic Con	dione	upathy		o givoir iii i ait i.				obably 4 Unknown
Ö	w require been si should I	etec	Respiratory o	tealwee	venhile	iter	clepend	ont-		-	_		
3ec	elaw hasb	ldr								_ 24a. Wa	san opsy forme∎?		topsy findings available completion of cause of
a F			- anomia							1 ☐ Yes	2 No		2 No
of Vital	hysicien: The law nis certificate has b I director, page 2 s	Be	25. Was case referred to med examiner?	-	ospital:				Other	Death (Check only			
ot	Phys this al dii	2	1 ☐ Yes 2 ☐ No  27. Manger of Death		1 Unpatie		ER/Outpatient 28b. Time of	3 DOA	Injury at	ng Home 5 ☐ Res 28d. Describe			cify)
L C	ding Phy h. After thi funeral o	lo	1 ☑Natural 5 ☐ Per	iding estigation	28a. Date of Inju (Month, Da	Year)	Injury	м 200	Work? 1 ☐ Yes 2 ☐ No	200. 00001100	now anju	ry occurred	
Division	Attending Physicien: r death. ector: After this certifica by the funeral director, i	fica	3 ☐ Suicide 6 ☐ Cou	ld not be	28e Place of Init	urv - At he	ome, farm, street			28f. Location	(Street ar	nd Number or Ru	ural Route Number,
ò	or A after Direction by	erti	4 ☐ Homicide det	benimed	building, et	c. (Specif	y)	, 1401019, 0		City or To	own, State	9)	
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical Certification:	29a. Certifier 1 Certi	ying Phys	ician: To the best	of my kno	wledge, death or	curred at	the time, date and p	lace, and due to the	e cause(s	and manner as	stated.
	24 h 24 h e Fur	dici	(Check only 2 Media	al Exemir	er: On the basis of and manner sta	f examina	tion and/or inves	tigation, in	my opinion, death o	occurred at the time	, date and	d place, and due	to the cause(s)
	vithin To the compl	Me	29b. Signature and title of cer	itier				29c. L	icense number		29d. Da	te signed (Monti	h, Day, Year)
	~ > F U		<b>&gt;</b> - <b>y</b>						D 3049 4	+	12	13/02/	
	8		30. Name and address of pers	on who co	mpleted cause of d	eath (Iten	n 23a) (Type, Prii	nt)					
	Open		KNESAIMS UT	i versi	ry specilli	y hes	chitel 60	=1 500	th charles	st Balh	more	MDYN	30
	Sta	ate	31. Date file DEC 1ay 0				ature de la la la la la la la la la la la la la						
- 1	Regist	rar	DEG TO	1004	1 Color	10	MARINE L						

DHMH 17 Rev 1/2001

SCHWIRGENMA, CHR. REE

			1 _ State	ype or Print in lend item State of Maryl		r physical properties of the physical p			400	39183
			Registrar     Decedent's Name (First, Middle, Last)			tinoate or i	Douin	2. Date of Dea	th	3. Time of Death
	Physici /Medi		Saverio A. Sche	embri				Decembe		
-	Examir	ner	4a. Facility Name (If not institution, give s	street and number)			r Location of Death		4c. County of D	
			7729 Warbler Lane 5. Social Security Number 6. Sec	7 Age //g	yrs. last birthday)	Rockvi	If Under 24 Hrs.	8. Date of Birth	Montgon	nery Birthplace <i>(State or Foreign</i>
	Funeral Director			M 2□F 76	Vre	Months Days	Hours Min.	(Month, Day March 2	, Year)	ew York
	Maryland	tor	10a. State 10b. County  Maryland Montgome		. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th the or 28¢	lred	10e. Street and Number			10f. Zip Code		1	log. Citizen of What	Country?
	th wi	al	7729 Warbler Lane			2085	55		United St	ates
36	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Heelth and Mental Hygiene. Important: if itam 27 is marked other than "natural", or Items 23a or 28e-1 ahow any Injury or other treumatic avant, the Modifiel Examinar must be notified at once.	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☑ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 对 Yes 2 □ No If Yes, Give		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - A Black, W Specify:	
21215-0036	natural	Completed b	15. Decedent's Edu (Specify only highest grade	Year or Dates: KO cation completed)	16a. Dece	dent's Usual Occup kind of work done OO NOT use retired	durina most of worki	ing	16b. Kind of Busine	•
121	withir sne. then	E G	Elementary/Secondary (0-12)	College (1-4or 5+)			,		United S	
	filled Hygie ther		17. Father's Name (First, Middle, Last)	4	Ele	ctrical E	18. Mother's Name	(First, Middle,	Governme Maiden Sumame)	11 L
an	d be antal cad o	o Be	Mario Schembri				Rosalia	Calandr	a	
Maryland	shoul nd Me marl marl	F	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailir	ng Address (Street			r, City or Town, State	, Zip Code)
	nd 2 alth a 27 is r treu		Amina Schembri/ N	√ife	7729	Warbler	Lane, Roc	kville.	Maryland	20855
ē,	s 1 a f Hee itam othe		20a. Method of Disposition	20	b. Place of Dispo	sition (Name of			20c. Location - City	
e E	Page ent o nt: If ry or		1 ☑ Burial 2 ☐ Cremation 3 ☐ F  '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Gate of Cemet	natory or other place Heaven	20	-	Silver Sori	g, Maryland
Baltimore,	permit. Depertminition imports any inju		21. Signature of Funeral Service License		)1405   Re	Name and Address Ockville, Ockville.			Pumphrey lontgomery	Funeral Home Avenue
	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition			er the mode of dyin				Approximate Interval Between Onset and Death 8 Months
	/Medical Examiner		resulting in death)	Due to (or as a cor	sequence of):					
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cor	sequence of):					
,092	te be executed ysician and ie burial-transit	a	that initiated events resulting in death) Last	Due to (or as a cor	sequence of):					
P.O. Box 68	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pri 1 □ Live birth 2 □ i 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy	,		23d. Date of o	delivery Day Year
	luires that n signed b uld be deta	b	Part II. Other significant conditions con	ntributing to death but not	resulting in the u	nderlying cause giv	en in Part I.			to the cause of death?  Probably 4 Dunknown
Records,	0 - 0	Completed		·				24a. Was a autops perform	sy prior t med? death	autopsy findings available occmpletion of cause of ?
ita	ician: Th certificate rector, pag	a	25. Was case referred to medical				26. Place of Death		~	
n of Vital	fing Physician:  After this certific funeral director,	on; To B	27. Manner of Death 1. Natural 5 □ Pending	fospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatier 28b. Time of Injury	28c. Injur Wor	y at k?		ence 6 Other (S) ow injury occurred	pecify)
Division	or Attenctert free death	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (Sp.	At home, farm, str pecify)		Yes 2 □ No	28f. Location (Si City or Town		Rural Route Number,
	To the Hospitel within 24 hours e To the Funerel Completely filled	Medical C		sician: To the best of my ner: On the basis of exar and manner stated.						
	To th within To th	Me	29b. Signature and little of certifier			29c. Licens	e number	2	9d. Date signed (Mo	nth, Day, Year)
			1 toller	715	$\supset$	D458	80		December 7	, 2004
0	1/		30. Name and addless of person who co	empleted cause of death	(Item 23a) (Type,	Print)				
1/	λ,		Leon Christopher	Hwang, D.O.	, 1396 I	Piccard D	rive, Roc	kville.	Maryland	20850
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) DEC 1 0 20	32. Regietrar's S	ignature	Loon	de :			

			For State	State of Marylan				lental Hy	giene	30121
			Registrar		Ce	rtificate of D	eath	2. Date of Dea	Reg. No. O O S	35104
t	Physicia	an	Decedent's Name (First, Middle, Last					Month	Day Year	3. Time of Death
	/Medic		Ethel M. Spe	ence		4b. City, Town, or L		Decembe	4c. County of Dee	9:44 AM M
	Examin	er	Shady Grove Advent			Rockvil			Montgome	
	Funeral		5. Social Security Number 6. S				If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, De)	h v, Year) 9. Bir	thplece (State or Foreign
	Director		281-22-5318	77	Yrs.			Sept. 2	7, 1927 Oh	io″
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or L	ocation				10d. Inside City Limits
	Mary In sh	tor	Maryland Montgome	ery Si	lver	Spring				1 ☐ Yes 2 ☐ No
	in the	Directo	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
	23a c		13312 Georgia Ave	enue		20906			United Sta	tes
	tems tems	Funerai	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of Hist tf Yes, specify Cuban,	panic Origin? (Spe , Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	
36	within 72 hours after death with the Maryland ene. Then *naturel', or tlema 23a or 28a-f show he Medical Examinar must be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify: W	nite
21215-0036	2 hou ature	ted	15. Decedent's Ed	ducation	16a. Dece	dent's Usual Occupat	ion		16b. Kind of Business	Andustry
215	thin 7.	Completed	(Specify only highest gra	Coitege (1-4or 5+)		kind of work done du DO NOT use retired)		ng		
N.	filed wil Hygien other th	Con	12		Tele	type Sette			Newspaper	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. If Health and Mental Hygiene ? nature!, or Items 23a or 28a-1 show then 21 a marked other then "nature!" or Items 23a or 28a-1 show other traumatic event, the Medical Exam has must be notified at	Be	17. Father's Name (First, Middle, Last)  David Robir			1	18. Mother's Name	(First, Middle, Sher	Maiden Sumame) rick	
Ž	should nd Me mark mark	은	19a, Informant's Name/Relationship		19b. Mail	ng Address (Street an	**		r, City or Town, State,	Zip Code)
	and 2 sealth ar n 27 is		Deborah D. Hackett	:/daughter	1				rsburg, MD	
altimore,	of Hee		20a. Method of Disposition	20b. P	-	osition (Name of matory or other place)	, i	Date	20c. Location - City or	
<u><u>E</u></u>	Pages nent of ant: If its ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specif	A11	. Soul	s Cemetery	18,	nber 2004	Germantown	
Balt	permit. Pages Department of H Important: If ite any injury or of once.		21. Signature Funeral Service Lice	M00877	Ro Ro	2. Name and Address ockville, l ockville, M	of FacilityRobe Inc., 300 Mary Land	rt A. I West M 20850	Pumphrey Fu Montgomery	neral Home/ Avenue
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death					rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a Pheumonia	1					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ			1.10			
<b>*</b>	LAGIIIIICI	_	Sequentially list conditions,	b. Sendome Due to (or as a consequence)	mbri	lhous C	0/1415			
	nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1	1					
,	te be executed ysician and le burial-transit	Examiner	that initiated events resulting in death) Last	c. <u>Lymphoma</u> Dye to (or as a consequence)	uence of):					
1760		ical	(	d						
89	± 00 €	Physician/Med	IF FEMALE:							
Вох	eath certific attending pl	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna	death 3	Ectopic pregnancy			23d. Date of de Month	livery Day Year
o.	that the death cert ed by the attendin detached for use	iyslo	1 ☐ Yes 2 Ø.No 9 ☐ Unknown	4☐ Pregnant at time of de 9☐ Unknown	eain 5	Other (specify)				
Δ.	uires that the signed by to detach	by Ph	Part II. Other significant conditions of	contributing to death but not resu	ulting in the u	inderlying cause given	in Part I.	23a. Did to	bacco use contribute to	the cause of death?
Records,	w requires been sign should be	ed b	Necrosis of	right che	51	wall		1 🗆 Y	es 200 No 3□P	robably 4 DUnknown
000	e law requ has been ge 2 should	Completed		U				24a. Was a		utopsy findings available completion of cause of
	The ate ha	Com						perfor 1 X Yes	med? death?	
Vital	Attending Physician: The ordeath.  ector: After this certificate by the funeral director, pag	Be (	25. Was case referred to medical examiner?	11			26. Place of Death	(Check only or	ne)	
	Physi this c	To	1 X Yes 2 No 27. Manner of Death	Hospital: 1 X Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatie	nt 3□ DOA Others	4   Nursing Ho		ence 6 Other (Spe	cify)
on	ding F h. After funera	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury 4:00	Work? 1 □ Ye	1	Leakag	& of chem	otherapy
Division of	Atten r deal sctor: by the	Ifica	3 Suicide 6 Could not b	e 28e. Place of Injury - At ho	me, farm, st	1	/\	28f, Lodarion (S	treet and Number or R	ural Route Number
á	s afte	Certification:	4  Homicide determined	building, etc. (Specify	Mice	2		Dr. #20	n, State) 2101 V	nedical Park ring MI)
	To the Hospital or Attending Physician: The within 24 burs after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical		nysicien: To the best of my kno miner: On the basis of examinal and manner stated.						
	To th within To th comp	Me	29b. Signature and title of certifier	- 1/ lu -	has &	29c. License	. ~11 ~		29d. Date signed (Mont	11001
			> fatural 10	mske nay	1 MX	1)5	51916		Dec. 6, 2	004
	10		30 Name and address of person who Patricia Tomsko	completed cause of death (Item Ndy, 1119 Kc	23a) (Type CKV//	Print) Pike, G	:-100, R	ockvil	Vec. 6, 2 le, MD 2	0852
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture 4	In				
100	3100		T O T	104	1	ryvours				

Fune Direc

"netural", or items 23a or 28e-f show

Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

permit. Pages 1 and 2 should be filed Department of Health and Mental Hygis Importent: If Item 27 is marked other

Physic /Medi Examir

Baltimore, Maryland 21215-0036

State of Maryland / Department of Health and Mental Hygiene (1)

30105

	•	1 - State Registrar				Cer	tificate	e of	Death	,	Reg. No.	04	JJ	100
		1. Decedent's Name	(First, Middle, La	st)						2. Date of De	ath Day	V	3. Tim	e of Death
siciar edica		REGINA	LD T. SM	IITH SR						NOVEMB		, 2004		PM
mine		4a. Facility Name (If	not institution, giv	e street and number)			4b. City,	Town, o	r Location of Death		4c. Co	unty of Deat	h	•
	á	920 PR	ESIDENT	ST. APT 5	1		ANN	APO	LIS		ANI	NE ARU	NDEL	
ral		5. Social Security Nu			ge (In yrs. last bi		If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th y, Year)	9. Birt	hplace (Sta	te or Foreign
tor		217-74		X 2 F	43	Yrs.				11-25-	1961	MAR	YLANI	)
		Usual Residence of I	10b. County		10c. City, Tov	vn or Lo	cation						10d. Insid	e City Limits
Š	5	MD.	N/A		BAL	ΓΙΜΟ	RE						1)	Yes 2 □ No
Director	ט	10e. Street and Num	ber				10f. Zip	Code			10g. Citizen	of What Co	untry?	
		916 E.	NORTH A	VE.			21	205			USA	A	,	
Financial		11. Marital Status		12. Was Decedent Armed Forces	Ever in U.S.	13. V	Vas Deced	ent of H	lispanic Origin? (Sp	pecify Yes or No	- 14.	Race - Ame		n,
ü	3	1 Never Marrie	d 2X Married	1 Yes 2 X			Yes 2		an, Mexican, Puerto Specify:	nican, etc.)	1	Black, White		
1		3 Widowed 4	Divorced	Year or Dates:			L 165 4	۱۷۵ نیم:	Specily.		Sp	ecify: BL	ACK	
0	נו נו	(Specif	15. Decedent's E fy only highest gr	ducation ade completed)	16a	(Give	ent's Usua kind of wor	k done	during most of work	king	16b. Kind	of Business/	Industry	
potologo	2	Elementary/Secon	dary (0-12)	College (1-4or	5+)		O NOT us	e retire	a)				4.3.700	
		-10- 17. Father's Name (F	First, Middle, Last			CO	<u>OK</u>		18. Mother's Nam	e (First, Middle		ESTAUR	ANT	
a	2		F. SMIT							H V. RI		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
Ę		19a. Informant's Nar			19	b. Mailin	a Address	(Street	and Number or Rui			wn State Z	in Code)	
			SMITH(MO				-		T ST APT		-			21403
1   1		20a. Method of Dispo			20b. Place of	of Dispos	sition (Nan	ie of	Ţ	Date		ion - City or		
		1 □ Burial 2 □ ' 4 □ Donation		Removal from State	HILL	CRES	atory or of T CEM	ETE	RY 12-2-	2004	ANNAPO	DLIS M	ARYLA	ND
oj				nsee LARRY R	EESE	22	Name an	d Addre	ss of Facility WM .	REESE	& SONS	S MORT	HARY	P.A.
ouce		<b>)</b> >	Lane	. Dees					T. ANNAPO					
		23a. Part1. Errer to	e disease, or con	plications that cause one cause on each I	d the death. Do				T.	-		-	Approxi	mate Between
an	1	Immediate Cause (F	Final	1115/									Onset a	nd Death
al		resulting in death)	-	aDue to (or as	a consequence	of):							10 1	years
ier		Constitution for	elikin na	h AIDS	Denny	tio	4						14	ear
i i	U	Sequentially list con- if any, leading to immorause. Enter Under	mediate 📕	Due to (or as	a consequence	of):								-
	8	cause. Enter Underly that initiated events		c						_				
		resulting in death) La	ast	Due to (or as	a consequence	of):								
I collocation	2			d							·			
100	NIC.	IF FEMALE:				-								
700	2	23b. Was decedent in the past 12 n			2 Fetal deat		Ectopic pro		,		23d.	Date of deli Month	very Day	Year
2	200	1 ☐ Yes 2 ☐ 9 ☐ Unknown		4∐Pregnant a 9□ Unknown	t time of death	5	Other (spe	ecity)					,	
welriewd wh befolence			cant conditions	contributing to death I	out not resulting	in the ur	derlying c	usa niv	en in Part I	23a. Did t	obacco use o	contribute to	the cause	of death?
1	, D			John John S	out mot rooming		aony mg o	au gr	on array	1 🗆 `	~			□Unknown
0	נוֹנוֹנוֹ													
2	5									24a. Was autor		prior to death?	ompletion	ngs available of cause of
; C	)							1 ☐ Yes	2 No		2 🗆 No			
a	۵	25. Was case referre		Hospital:				Δ Oth	26. Place of Deat				мот	HERS
ŀ	- 1	1 Yes 2 X N 27. Manner of Death		1 ☐ Inpati		utpatient Time of		-	4 - 14d13ll1g11c	ome 5 Resident		Other (Spec	HOM	
		1 Natural	5 Pending investigation	(Month, Da	ay Year)	Injury	М	3c. Injur Wor 1 🗆	yat k? Yes 2 □ No	234. 2334100	injury oc	Juliud	10.000	<del>101</del> 141:

To the Hospitel or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, ≤ After this within 24 hours after deatl To the Funeral Director: completely filled in by the

Certifica

Medical

State Registrar

3 🗌 Suicide

29a. Certifier

4 Homicide

me and address of person who completed cause of death (Item 23a) (Type, Print)
DR. RICHARD NETTLES 600 WOLFE ST. BAI 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

6 Could not be determined

32. Registrar's Signature

MD

600 WOLFE ST. BALTIMORE, MARYLAND 21218

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

DØ\$61554

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

DECEMBER 2, 2004

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygien [ ]

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death **Physician** 04 /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death **Examiner** 4c. County of Death Baltimore Medica Saltimor If Under 1 Year If Under 24 Hrs.
Months Days Hours Min 5. Social Security Number Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 10 M 2□F (Month, Day, Year) Jan, 10, 1928 230.28-493 Director 76 Virginia Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location item 27 le marked other then "naturel", or Items 23a or 28a-f show other traumatic event, the Medical Example and 10d. Inside City Limits MD N/A Completed by Funeral Director Baltimore City 1 Yes 2 □ No 10e. Street and Number 4021 Eastern Avenue 10f. Zip Code 10g. Citizen of What Country? 21224 United States 12. Was Decedent Ever in U.S. Amed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No White 3 ☐ Widowed 4 ☐ Divorced Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 Contractor Contruction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Hamilton Cimpkins ပ Bertha Simpkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Simpkins (Wife) 4021 Eastern Avenue item 27 Balitmore, Maryland 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ō ö 1 X Burial 2 □ Cremation 3 □ Removal from State Department of Importent; If any injury or once. `4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemer Cem 12/7/04 Baltimore, Maryland 21. Sign of Funeral Service Licensee Charles S. Zeiler & Son, Inc. 6224 Eastern Avenue Balitmore, MD 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or like art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Preumonia /Medical Due to (or as a consequence of) Examiner Brain Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed s consequence of): use as the burial-tran nding physician and P.O. Box 68760, Physician/Medical Artery IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy the atte in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Be Completed 1 🗌 Yes 2 🗆 No 3 Probably 4 TUnknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has 2 L No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 1 ☐ Yes 25 No Certification: To 17 Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred After 1 Natural
2 Accident 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AU 4176435 515132 December 4th, 2004 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) Street, BALTIMORE MARYLAND, 21201 SHAH KEYUR South Greene 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

DEC 1 0 2004

32. Registrar's Signature oaiks! ORIGINAL

DHMH 17 Rev 1/2001

Registrar

DEC 1 0 2004

2004

DECEMBER

RICHARD TILGHMAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Taranto rcember Grace /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Chesapeake Air Be Mel Center Har ford 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 6. Sex Birthplace (State or Foreign Country) Days 1 M 2 4 190 - 26 - 499 Usual Residence of Decedent Director 12/7/32 10a State 10h. Count 10c. City, Town or Location 10d. Inside City Limits Fores Director 1 HOS 2 No mn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2/050 or Itams 23a USA vas Decedent Ev Armed Forces? Yes 2 No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2 No White þ Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. important: if itam 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Co. Board of Education 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MILLER FRANCIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Taranto Spousele Lockhart Cir., Apt. F., Forest Hill MD 2/050 Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State

1 Donation 5 Other (Specify) Bel Air Num. Gardens 12-7-04 Bel Air, MD 22. Name and Address of Facility NEWPORT DR. FORESTHILL, MD EVANSFUNCIAL CHAPEL-BELAIR 21050 23a. Part1. Enter the disea. ..., or complication, that shock, or heart failure. List only the cause on aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician extrem. +x Lower 36 hrs disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** ulable Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-tran IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed pertension 25. Was case referre 2 1 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) <sup>o</sup>L 1 | Yes /2 | 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DQA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Hospital or Attanding Division 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier The Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. To tha complet 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) U00 60282 12/6/2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chasapeake Dr

State Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

520

32. Registrar's Signature

Mac Krell

31. Date filed (Month, Day, Year)

/Medi Examin	an	Decedent's Name (First, Middle, Last	t)			· · · · · · · · · · · · · · · · · · ·	2. Date of D		Vear Year	d. Time of Deat
Evami		Elizabeth Margare					DEC.	2, Day		1051 A
LAdiiii	ner	4a. Facility Name (If not institution, give 536 STONEYHILL	COURT		ODEN				County of Death	NDEL
Funeral Director		210-42-3873	9X 7. Age (In yi	s. last birthday 60 Yrs.	Months Day		in. 8. Date of B (Month, D Mar 22	ay, Year)	Cour	
A.		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or L	ocation				1	0d. Inside City Lim
f sho	ō	MD Anne Aru	ındel Od	lenton						1 □ Yes 2 <b>)</b> (1
288- norm	Director	10e. Street and Number			10f. Zip Code	9		10g. Citiz	en of What Cour	ntry?
38 OI		536 Stoney Hill Co	ourt		21113			Unit	ed State	es
"naturel", or items 23e or 28a-f show olical Examiner coust be notified at	Funeral	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in Amed Forces?  1  Yes 2 No If Yes, Give	U.S. 13.	Was Decedent of If Yes, specify C	uban, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)		4. Race - Americ Black, White,	etc.
le i	d by	3 ☐ Widowed 4 Divorced	Year or Dates:		10 163 29	о эрвену.			Specify: White	:
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other then		10 17. Father's Name (First, Middle, Last)		nomen	laker	18 Mother's N	lame (First, Middle	Maiden S	Sumame)	
of Health and Mental P fitem 27 Is marked of r other traumatic eve	To Be	John Muller				Alice	Kiem			
ls m	i	19a. Informant's Name/Relationship (7	•				Rural Route Numi			
Healt		Robin Bergman/Dau  20a. Method of Disposition			osition (Name of	od Diive,	, Frederi		ation - City or To	
0 10 10 10 10 10 10 10 10 10 10 10 10 10		1 Burial 2 Cremation 3 🗆	Removal from State	cemetery, cre	matory or other p	1	Dec 9			
rtent rtent njury		* 4 ☐ Donation * 5 ☐ Other (Specify 21. Signature of Funeral Service Licen	7/2-10		ke Crema	- 1	2004		sville,	MD
Department of the Importent: If ite any injury or of once.		23a. Part1. Enter the disease, or comp	ett		8717 Gre	en Pastu	neral Al	e Ba	tives ltimore,	MD
aminer transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cons c. Due to (or as a cons							
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ne attending physed for use as the	hysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	etal death 3 [	□Ectopic pregnal □ Other <i>(specify)</i>			23	3d. Date of delive Month	ory Day Year
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ter death. irector: Atter this certificate has been signed by the attending phys n by the funeral director, page 2 should be detached for use as the	To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months?  1	Hospital:  2   Fe   Popular    1   Inpatient   2   Fe    4   Pregnant at time of some	esulting in the u  ER/Outpatie  28b. Time o Injury	Other (specify)  underlying cause  nt 3 DOA  of 28c. In  W  M  1	given in Part I.  26. Place of E  Other: 4 Nursing jury at lork?  Yes 2 No	24a. Waautu peri 1 2 Yes Death (Check only Brown 5 Res 28d. Describe	tobacco us Yes 2 X s an ppsy ormed? 2 \( \sigma \) No one) idence 6 how injury	Month e contribute to the Solution of the Contribute to the Contribute of the Contri	Day Year  ne cause of death? ably 4  Unknow  psy findings availal mpletion of cause of 2  No  AT SCEN
ter death. irector: Atter this certificate has been signed by the attending phys n by the funeral director, page 2 should be detached for use as the	Certification; To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months?  1	Hospital: 1 Inpatient 2  28a. Date of Injury (Month, Day Year)	esulting in the use ER/Outpatie 28b. Time of Injury  home, farm, st	other (specify)  Int 3 DOA  of 28c. In  W  M  1  Treet, factory, office  th occurred at the	26. Place of EDther: 4 Nursing Jury at Jork?  Yes 2 No	24a. Wa auto per 1 1 2 Yes Death (Check only g Home 5 Res 28d. Describe 28f. Location City or To	tobacco us Yes 2 1 s an yes yes yes yes yes yes yes yes yes yes	Month  e contribute to the No 3 problem Proprior to cordeath?  1 Vers  Other (Specify occurred	Day Year  ne cause of death? ably 4 Unknow  psy findings availal impletion of cause of 2 No  // AT SCEN
death. vtor: Atter this certificate has been signed by the attending phys the funeral director, page 2 should be detached for use as the	To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months?  1	Hospital:  28a. Date of Injury (Month, Day Year)  28b. Place of Injury - At building, etc. (Spe	esulting in the use ER/Outpatie 28b. Time of Injury  home, farm, st	other (specify)  Int 3 DOA 28c. In 1 Street, factory, office th occurred at the investigation, in m 29c. Lice	26. Place of EDther: 4 Nursing Jury at Jork?  Yes 2 No	24a. Wa auto per 1 1 2 Yes Death (Check only g Home 5 Res 28d. Describe 28f. Location City or To	Yes 2 X s an ppsy ormed? 2 No one) idence 6 how injury (Street and wwn, State)	Month  e contribute to the contribute to the contribute to the prior to condeath?  1 Ves  Cother (Specify occurred)  Number or Rura  and manner as stellace, and due to signed (Month, in the contribute of the co	Day Year  ne cause of death? ably 4 Unknown psy findings availal impletion of cause of 2 No  1/ AT SCEN  I Route Number.  ated. the cause(s)

			For State Registrar	State of Maryland / [	Department of H Certificate of I		ental Hygien Reg. N	ZHHLE '	39191
			1. Decedent's Name (First, Middle, Li	ast)			2. Date of Death Month Da		3. Time of Death
	Physicia /Medic		Edna L. Teac	jue			December	7 2004	8:10 Ma
	Examin		4a. Facility Name (If not institution, gi	ve street and number)	4b. City, Town, or	Location of Death	40	. County of Death	
12.0			1701 St. Marga		Annapo			ne Arunde	
	Funeral		Social Security Number     6.	Sex 7. Age (In yrs. last bit	nthday) If Under 1 Year Months Days	Hours Min.	B. Date of Birth (Month, Day, Year C 8 19	) 9. Birthplac Country 39 Mary	a (State or Foreign
tų S	Director		214-38-9127 Usuel Residence of Decedent	64	,,,,	Ψ	ec. 8 19	J9 Mary	Land
	land ow		10a. State 10b. County	10c. City, Tow	n or Location			10d.	. Inside City Limits
	Many -f sh	to	Maryland Anne A	Arundel Anna	polis				1 ☐ Yes 21 No
	r 28a	Director	10e. Street and Number		10f. Zip Code		10g. C	itizen of What Country	?
	h with		1701 St. Marga	arets Road	2140	1		USA	A
	deat	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H tf Yes, specify Cuba	ispanic Origin? (Spec	ify Yes or No- lican, etc.)	14. Race - American Black, White, etc	
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or flems 23a or 28a-f show aumatic event, the Medical Examinating to notified at	by	1 ☐ Never Married 2万 Married 3 ☐ Widowed 4 ☐ Divorced		1 ☐ Yes 25€ No	Specify:			ack
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<u>  \                                   </u>	ould Men Marke	은	George Hens		o. Mailing Address (Street	0,11			ode) 01401
2	s 1 and 2 should I Health and Men Item 27 is marke other traumatic		19a. Informant's Name/Relationship Charles Teague			Margare	ts Rd. A	nnapolis	, Md.
ore	of Health of Health filem 27		20a. Method of Disposition 1 ⊠Burial 2 ☐ Cremation 3	Cemete	of Disposition (Name of ary, crematory or other plac	ce)		ocation - City or Town	
Ĕ	Pag ment ant: t		*4 □ Donation 5 □ Other (Spec		and Vetera	n 12/1	0/04 Cr	ownsville	e, Md.
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ott		21. Signature of Funeral Service Lic	ensee Rese MOG 483	22. Name and Addre	se & Son	1 West S s Mortua	t. Annapo	olis,Md. 21401
	igen Types		23a. Part1. Enter the disease, or co	mplications that caused the death. Do by one cause on each line.	not enter the mode of dyir	g, such as cardiac or	respiratory arrest,	ln ln	oproximate nterval Between
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ta	(0	Be C	25. Was case referred to medical			26. Place of Death			
<b>\</b>	Physician: this certific ral director,	To E	examiner? 1 Tyes 2 D No	Hospital: 1 ☐ Inpatient 2 ☐ ER/O	dipatient 30 DOA		ne 5 Desidence	6 ☐Other (Specify)	
0	Jing Phy. After thi funeral		27. Manne of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury 28b. (Month, Day Year)	Time of 28c. Injury		8d. Describe how in	ury occurred	
Sio	Attending in death.  ector: After by the fune	catio	2 Accident investigat	l ha		Yes 2 □No			
Division of	or Attendate death	Certification:	3 Suicide 6 Could not 4 Homicide determine		farm, street, factory, office	2	City or Town, Sta	and Number or Rural F te)	toute Number,
	Hospital 24 hours a Funeral E		29a. Certifier 1 Pertifying	Physician: To the best of my knowledge	ne death occurred at the ti	me date and place a	nd due to the cause	s) and manner as state	ed.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	(Check only 2 Medical Ex	aminer: On the basis of examination a and manner stated.	ind/or investigation, in my	ppinion, death occurre	ed at the time, date a	nd place, and due to th	he cause(s)
	To the within 2 To the complet	Me	29b. Signature 317 title of contifier		29c. Licens	se number	29d. C	ate signed (Month, Da	ay, Year)
	F > F 0		1 (Allen	y boalars	MD D.	36091	/	2/9/21	004
	•		30. Name and address of person wh	no completed cause of death (flern 23a	29c. Licens (Type, Print) 888 8 8	00TO 10	5 00 0	NALADOLI	C ND21412
	3		ANTHONY	BOAKYEUND	888 B	ES / UMI	2 NA M	TIYITIVE	, , q , , , , , , , , , , , , , , , , ,
		ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	A los				
	Regist	rar	ner 1 (	2004 Deneura	17 Ann	10. 1			

ORIGINAL

		1	For State Registrar	State of Marylan		artment of H			iene g. No. 00	4 39192
			Decedent's Name (First, Middle, Las	t)				2. Date of Death	1	3. Time of Death
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	edica mine		4a. Facility Name (If not institution, give		1110000		r Location of Death	Occurs	4c. County of	
LAU	;	"	Franklin Square	Hospital Cer	nter	Rosedo	ue		Balti	more
Fune	ral		5. Social Security Number 6. S		last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthplace (State or Foreign Country)
Direc			262 36 2146 C	M 20 F 78	Yrs.	Month's Days	Hours Will.	APRILS	1936 F	LORIOA
p .		- I	Usual Residence of Decedent  10a. State 10b. County	10c Cit	y, Town or Lo	nation		1		10d. Inside City Limits
aryla ehov					) - 0. 1	\\				1 ☐ Yes 2 No
he M		Director	WORKTON 12 UTILIN	01/2	E RRY	HALL		1/	g. Citizen of Wh	
death with the Maryland ms 23a or 28a-1 ehow	9		10e. Street and Number	000 0 00		10f. Zip Code			i i i i i i	Country?
sath 1	2	Funeral	3727 EAST JOY	12. Was Decedent Ever in U	C 13	Was Decedent of H	ienanie Origin? (Sr	pecify Yes or No.	14 Bace -	- American Indian,
ter de		Ę.	11. Marital Status  1 ☐ Never Married ➤ Married	Armed Forces?	.0.	If Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)		White, etc.
Us at	100	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates: W	77	1 ☐ Yes 25 No	Specify:		Specify:	WHITE W
vithin 72 hours after ene.	100	g eg	15. Decedent's Ed	ucation	16a, Dece	dent's Usual Occup	ation		16b. Kind of Busi	iness/Industry
ינו יי	T A	ble	(Specify only highest gra	College (1-4or 5+)	life.	kind of work done of DO NOT use retired	during most of won d)	ing	PRILLIA	ms CRAnz
Z Z d with	9	Completed	iayrs.		125	FEMP.	-owni	R	SIRVIG	37I, 50
Maryland 2 Id 2 should be filed a Ith and Mental Hygis 27 Is marked other	Ne ii	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, M	faiden Sumame)	1
aryland 21215-0036 should be filed within 72 hours after death with the Marylar nd Mental Hygiene. in marked other then "natural", or Itams 23e or 28e-1 ehow		2	FRAZIER L	Mill Kali	iAMS		<u>03/12</u>	HALSO	MBACI	1
CO :: = m -	-		19a. Informant's Name/Relationship	Type, Print)	19b. Maili	ng Address (Street	and Number or Ru	ral Route Number,	City or Town, St	tate, Zip Code) 21236
and and m 27	or other traditions		MARLARST WI	LIAMS	3737	SAST JOI	PA (TOAL	LTESTA	AL LIP	RYLAND
Ore lest of H	5		20a. Method of Disposition	,	cemetery, cre	osition (Name of matory or other place		Date 2	20c. Location - Ci	ity or Town, State
altimore, mit. Pages 1 ar partment of Hea	2		'4 ☐ Donation 5 ☐ Other (Specific	10 5		PHILLIA		071 F	OBLIV	Charthan 1, ne
Baltimore, Mi	once.		21. Signalium al Funera Sarvida Cicer	se	2	2. Name and Addre	ss of Facility	moRiss	· w.	
	s OI		THOU IF CUT	-//		3800 HAV	रान्तरक रिठ	ed tark	11/2/1/	Approximate
	п		23a. Part1. Enter the disease, or com shock, or heart failure. List only	one dause on each line.	n. Do not en	ter the mode of dyin	ig, such as cardiac	or respiratory arre	SI,	Interval Between Onset and Death
Priysic	_		Immediate Cause (Final disease or condition resulting in death)	a acute m	yoca	idial ir	rfarcti	00		
/Medi Examii			resulting in dealiny	Due to (or as a conseq	unce of):					
		<u>.</u>	Sequentially list, conditions,	b. COPD	жерее об-					
1/12 3	ISI.	nine	r any, leading to infineulate cause. Enter Underlying Cause (Disease or injury		,,,,					
xecul	al-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a conseq	juence of):					
18760, crate be executed physician and	tne burial-transit	dical E		d						
68 ificate		edic					W.			
Box 6 leath certific attending p	esn	Z	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnancy			23d. Date	of delivery
Geath e atte	D0 D0	lcia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of c		Other (specify)	<u> </u>		Month	h Day Year
, P.O. I that the de	Iache	hys	9 Unknown							
I Records, P.O. Box 6. The law requires that the death certific ate has been signed by the attending p	ep eg	Completed by Physician/Me	Part II. Other significant conditions of	ontributing to death but not res	sulting in the t	inderlying cause giv	en in Part I.		5.7	oute to the cause of death?
Records, he law requires to a has been signed	spould	ted	USThma					1 🗆 Ye	s 2 No 3	Probably 4 Unknown
Recc	N SI	ple	DM					24a. Was ar autops	y pri	ere autopsy findings available for to completion of cause of
The ate h	page	Con						perform 1 ☐ Yes 2	ned? dea	ath? ⊒Yes 2⊡No
of Vital F Physician: Th rthis certificate		Be (	25. Was case referred to medical examiner?					th (Check only one	9)	
of V	al dire	ို	1 ☐ Yes 2 No		ER/Outpatie	-	4   Nuising I	ome 5 Reside		
On C ding P After t	unera	on	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor	k?	28d. Describe ho	w injury occurred	1
Division of Vital of Attending Physician: after death.	the t	Certification;	2 Accident investigation 3 Suicide 6 Could not b				Yes 2 □ No	28f Location /St	root and Number	or Rural Route Number,
or At	in by	ırtifi	4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	fy)	reet, factory, office		City or Town	, State)	or Aurai Abute Number,
Division Hospital or Attending A hours after death. Funaral Diractor: After	lled		29a. Certifier 1 Certifying Pt	ysician: To the best of my kno	nwledge dea	th accurred at the tir	me date and place	and due to the ca	use(s) and man	ner as stated
Hos 24 ho	stely	edical		niner: On the basis of examina and manner stated.						
To the Hospital within 24 hours a To the Funaral C	completely filled in by	Med	29b. Signature and title of certifier	1 /		29c. Licens	e number	25	9d. Date signed (	(Month, Day, Year)
⊢ <i>s</i> ⊢	O		Mach 1/1	Mans	•	Don	2769:	3	Ecemb	er 4, 2004
			30. Name and address of person who	completed ause of death (Iter	m 23a) (Type		ا تا ي		WIIIO	4 1,0001
6	741		Dr. Michael Hu			square I	Drive By	ut mo	2123	7
v.	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	Ana	W. 1	,		

State Registrar

W.

30. Name and address of person who completed cau e of death (Item 23a) (Type, Print)

CURTIS W. OLLAYOS, MOGODCATONAUE BALTIMORE, MO 2/229
31. Date filed (Month, Day, Year) 32. Registrar's Signature

D39177

DEC OG

MD

			For State Registrar		State of	f Marylan	id / Depa <i>Cei</i>	artmen <i>tificat</i>	t of H e of L	ealth and D <i>eath</i>	d Menta	al Hygier	2004	3919	94
	Physici	ian	Decedent's Name (F  John		istuba,	C-n					Me		Day Year	3. Time of De	
	/Medie Examir		4a. Facility Name (If no		· · · · · · · · · · · · · · · · · · ·			4b. City,	Town, or	Location of De			06, 2004 4c. County of Death	7:05	ΡМ
	LAGITIII		10733 Lak		Way					sville			Baltimore	!	
	Funeral Director		5. Social Security Number 200-20-475	2 17	ex X∏M 2□F	7. Age (In yrs. 76	last birthday) Yrs.	If Under Months		If Under 24 F Hours M	lin. (M	ite of Birth Jonth, Day, Yea CCh 26,	9. Bint Con 1928 Mas	place (State or Fo Intry) SSACHUSET	
	laryland ehow		Usual Residence of De 10a. State 10	Ob. County		10c. Cit	y, Town or Lo	cation						10d. Inside City L	imits
	e Mar 3e-fet liffed	ctor	Md.	Baltimor	re	Co	ckeysv	ille						1 🗆 Yes 2	₽No
	with th	Funeral Director	10e. Street and Number					10f. Zip		04.050		10g.	Citizen of What Cou		
	ns 23	eral	10733 Lake	espring		dent Ever in U.	.S. 13. V	Vas Deced		21 030 spanic Origin?	(Specify Y	es or No-	14. Race · Amer		
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "neturel', or Items 23e or 28e-f ehow any injury or other treumetic event, the Mcdreil Examiner must be muilted at ance.	by	1 ☐ Never Married 3 ☐ Widowed 4 ☐		Armed For 1 Yes If Yes, Giv Year or Da	2 □ No e	1	Yes, spec		spanic Origin? n, Mexican, Pu Specify:	èrto Rican,	etc.)	Black, White	, etc.	
5-0	72 ho 'netur	Completed		. Decedent's Ed only highest gra			16a. Deced	kind of woi	rk done d	uring most of v	working	16b.	Kind of Business/l		
2121	within ene. then "	mpl	Elementary/Seconda	ary (0-12)	College (1		Self	OO NOT us	se retired)			0.	ccounting		
	illed Hygie other	0	17. Father's Name (First	st, Middle, Last)	1-	F	0611	CIIIDT		18. Mother's N	lame (First,	, Middle, Maid			
ylar	nould be I Mental narked c	To B	Frank l	Wistuba						Lillia	n Ma	igee			
Maryland	12 sho h and 7 Is mu treum		19a. Informant's Name	, ,									y or Town, State, Zi		
	1 and Health tem 27 other tr		Mr. John Williams 20a. Method of Disposi		Jr./ Sc	20b. P	lace of Dispos	sition /Nan	ne of	- 1	Date		ium, Md. Location - City or T		
m <sub>o</sub>	Pages nent of int: If its iry or o		1 ☐ Burial 2 🔯C 1 ☐ Donation 5 [			state	emetery, cren 11top 9	-		140	9-04	To	owson, Md	•	
Baltimore,	permit. Page Department of Importent: If any injury or once.		21. Signature of Fund	al Service Licen	5 P		22	Name an	d Address	s of Facility	arol l	Home, I			
	20 = a 0	Н	23a. Part1. Enter the c	disease or comm	olications that ca	aused the death		1050	Vork	Rd T	nuson.	_McL 2	1204	Approximate	
	Physician		snock, or neart ra	allure. List only o	one cause on ea	ach line.								Onset and Dear	th
7	/Medical		disease or condition resulting in death)	-		or as a consequence		מא פו	ova	SCHLOT	DIS	es s		15 years	
	Examiner	-	Sequentially list condit	ions,	b. Does to di	or as a consugi	iones -fi								
	uted d ansit	Examiner	cause. Enter Underlyin Cause (Disease or inju- that initiated events	ng iry		20 00 0 00 00 00 00 00 00 00 00 00 00 00	isomio-cij.						1		
,0	icate be executed physician and s the burial-transit	Exa	resulting in death) Last		Due to (	or as a consequ	uence of):								
68760,	physic the br	edical			d		<del></del>								
Вох 6			IF FEMALE: 23b. Was decedent pre	egnant	23c. If yes, out								23d. Date of deliv	erv	
o.	law requires that the death certif as been signed by the attending 2 should be detached for use a	Physician/M	in the past 12 mor 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	nths?		rth 2 ☐ Fetal ant at time of de wn		Ectopic pro Other (spo					Month	Day Year	
ds, P	uires that n signed to ld be deta	by	Part II. Other significan	nt conditions co	ontributing to de	ath but not resu	ulting in the un	derlying ca	ause givei	n in Part I.	23	e. Did tobacco	use contribute to t		
Records,	aw requir s been si 2 should	Completed									24	a. Was an	24b. Were auto	opsy findings avai	lable
- R	The ate h	Com			_						10	autopsy performed? Yes 2 1	death?	mpletion of cause 2 No	e of
Vital	Physicien: The this certificate haral director, page	Be	25. Was case referred examiner?		Hospital:					26. Place of D	eath Chec	ck onl one			
of	Phys or this oral dir	); To	1 Yes 2 No 27. Manner of Death		28a. Date o	f Injury	ER/Outpatient 28b. Time of		8c. Injury Work	4   Nursing	-	Residence	6 ☐Other (Special	fy)	
ion	utending F death. ctor: After y the funer	atlor	2 Accident	Pending investigation		n, Day Year)	Injury	М		? es 2□No					
Division	el or Attending s after death. Il Director: After ed in by the fune	Certification;	3 ☐ Suicide 6 4 ☐ Homicide	Could not be determined	286. Place	of Injury - At ho g, etc. <i>(Specif</i> y	ome, farm, stre	et, factory	, office		28f. Loc Cit	cation (Street a by or Town, Sta	and Number or Rura ite)	al Route Number,	
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical	29a. Certifier 1 (Check only one)	Certifying Phy Medical Exam	ysician: To the liner: On the ba and mann	sis of examinal	wledge, death tion and/or inv	occurred a estigation,	at the time in my opi	e, date and pla inion, death oc	ce, and due curred at th	e to the cause( ne time, date a	(s) and manner as s nd place, and due to	tated. the cause(s)	
	To tl To tt comp	ž	29b. Signature and title	of certifier		1		29c	. License	_		29d. D	ate signed (Month,	Day, Year)	
,	, d -		الماعا	me W	1 De	puty		1		667		Dec	ember 7,	2004	
10	1 AP		Ph: I: p M:	of person who c	ompleted cause	death (It m	23a) (Type, f	Print)		+600.00	No M	anda	2109	2	
	Sta					,	ture	1	3		- 14 111	YIM	2,01	<i></i>	
	Registr	ar	DEC	1 0 201	n4   1	courses	19	ho	The state of	7					

DHMH 17 Rev 1/2001

WISTURA

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Ma	iryianu		tificate o			vientai ny	Reg. No			
	Physici /Medic		1. Decedent's Name (First, Middle, La. Luther Gass	saway Wel	sh					2. Date of De Month Decembe	Da	<b>200</b> 0		8:45 A <sup>M</sup>
	Examir		4a. Facility Name (# not institution, give Charlotte Hall Ve		me		4b. City, Town	n, or Location		1		County of D		
	Funeral Director		212 10 7302	ex 2□F	(In yrs. las 94	t birthday) Yrs.	If Under 1 Ye Months Da		er 24 Hrs. Min.	8. Date of Bir (Month, Da OCt • 8	th	10		State or Foreign nd
	yland how		Usual Residence of Decedent  10a. State 10b. County		10c. City, 1	Town or Loc	ation						10d. Ins	ide City Limits
	the Ma	Director	MD St. Mai	ry's	Cha	rlott	e Hall				10.00		4	Yes 2 No
	h with 1	al Dir	29449 Charlotte	Hall Road			10f. Zip Cod	20622	2		10g. Ci	tizen of What USA	Country?	
920	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "neturel", or tema 23a or 28a-f show event, the Mediral Examinar must be muited at	by Funeral	11. Marital Status  1XXNever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 □XYes 2 □ N If Yes, Give Year or Dates:	19/11		/as Decedent of Yes, specify C			pecify Yes or No Rican, etc.)		14. Race - A Black, W	merican Ind /hite, etc. White	ian,
21215-0036	e filed within 72 hor al Hygiene. I other than "neture vent, the Mcolonia	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 12th		+)	(Give H	ent's Usual Oc and of work do O NOT use ret	ne during m ired)	ost of wor	king	Ci	ind of Busine tizens Bank		onal
מ	al Hygid I other	Be C	17. Father's Name (First, Middle, Last)						ther's Nam	ne (First, Middle,	Maider	Sumame)		
Maryland	2 should be and Mental is marked o	2	Luther Welsh  19a. Informant's Name/Relationship (	Type Print)		19b Mailin	Addross /Stm			North	or City	Town Cto 4	7:- 0	
	and 2 s alth an 127 is or trau		Elizabeth Compton	**						, Laurel	-			
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 is marked any injury or other traumetic express.		20a. Method of Disposition 1 ☐ Burial 2 1 Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specific	Date 0/2004		ocation · City enton ,		ate						
Bait	permit. Departr Imports any inj		21. Signature of Funeral Service Licer		00773					naldson , Laurel				P.A.
68760,	Physician // Medicale pe executed // Medical Examiner as the purat-transit as the purat-transit	Aedicai Examiner	shock, or héart faffure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last		iac a consequen nosc a consequen		rrhy bic C	Hnm wrdi'	0Vá	scular	di	Leave	Onset	al Between and Death
P.O. Box 68	death cer e attendir id for use	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 Fetel de	ath 3 🗆	Ectopic pregnal Other (specify)					23d. Date of o	delivery Day	Year
	iw requires that s been signed by should be deta	by	Part II. Other significant conditions o	ontributing to death bu	it not resultin	ng in the un	derlying cause	given in Par	t I.			use contribute		e of death?
al Kecords,	The la ate ha: page 2	24a. V									an isy rmed? 2/2/No	24b. Were prior to death	to completion?	dings available n of cause of
1 VII	Phyaicien: r this certific ral director,	To Be	25. Was case referred to medical examiner?  1 □ Yes 2 □ No	Hospital: 1 ☐ Inpatier	nt 2□ER	/Outpatient	3□ DOA	\.L		h <i>(Check only o</i> ome 5 ☐ Resid		6 🗹 Other (S	pecify) A3	ST LIVI
Division of Vital	ding h. After fune		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		y 28 Year)	b. Time of Injury				28d. Describe h				
ŠĬ	To the Hospitel or Attentwithin 24 hours after deatl To the Funeral Director:	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	building, etc	. (Specify)					28f. Location (5 City or Tox	m. State	)		Number,
	To the Hospitel or A within 24 hours after To the Funeral Directorpletely filled in by	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of niner: On the basis of and manner sta	examination	dge, death and/or inve	occurred at the estigation, in m	time, date a	and place, eath occur	and due to the or	cause(s) date and	and manner place, and d	as stated. lue to the car	use(s)
I	To the within To the compl	Me	29b. Signature and title of certifier	huc		•	29c. Lice D	se numbe	573			te signed (Mo		
	5+1		30. Name and address of person who of the second se	le chu	nchi	ton	rint) GV	AN	. C	sila;	カル	A D	075	7
	Sta	_	31. Date filed (Month Day Year)	2004 32. Registra	r's Signature	19	Son	ukas						

			State of Maryland / Department of Health and	Mental Hygie	eng not.	20100
			1 - Stata Certificate of Death		NG. U U 4	39196
	Physicia		1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al -	Douglass Andrew Williams  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Dea	December	c 5, 200 4c. County of Deat	
	Examin	er	10745 Autumn Splendor Drive Columbia		Howard	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Min. Months   Days   Hours   Min.		Q Rint	nplace (State or Foreign untry)
	Director		579-20-1209 80 Yrs.	August 17,	1924 Wa	
	and and	}	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		- S	10d. Inside City Limits
	Mary II. o	ţō	MD Howard Columbia			1 □ Yes X No
	th the	irec	10e. Street and Number 10f. Zip Code	10g	. Citizen of What Co	untry?
	s 23e	ral	10745 Autumn Splendor Drive 21044	Specify Ves or No-	USA 14. Race - Ame	ncan Indian
356	be filed within 72 hours after death with the Maryland ital Hygiena.  d other then "naturel", or items 23e or 28e-f show event. It e Madical Examiner must be natified at	by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married	rto Rican, etc.)	Black, White	
21215-0036	72 hou		15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of work done during most of work done during most of work done during most of work done		b. Kind of Business/	Industry
2	filed within 72 Hygiena. sther then "nal ent, II e Modic	Completed	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)			C 77 111
2	filed w Hygier Ather th		2 Photographer  17. Father's Name (First, Middle, Last) 18. Mother's Na	ame (First, Middle, Ma		tute of Health
Maryland	d ba f ental l ced of	To Be	Unknown			
ar Z	2 should ba filed v and Mental Hygie Is marked other t reumatic event, IL	-	19a. Informant's Name/Relationship ( <i>Type, Print</i> )  19b. Mailing Address ( <i>Street and Number or F</i>		City or Town, State, 2	Zip Code)
	and 2		Bessie Williams/ Wife 10745 Autumn Sple			
Baltimore,	Pages 1 nent of He ant: If iten ary or oth		20a. Method of Disposition 1 □ Burial 2 🖫 Cremation 3 □ Removal from State		c. Location - City or	Town, State
Ħ	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 Is marke eny injury or othar treumatic <u>once</u> .	l	. 4 □ Donation s □ Other (Specify)  21. Signature of Funeral Septice Licensee  22. Name and Address of Facility i			os Ing
Ba	permit. P Departmo Importar eny injui	l l	5555 Twin Knoll			
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardishock, or heart failure. List only one cause on each line.	ac or respiratory arres	t,	Approximate Interval Between
	Pnysician	1 10	Immediate Cause (Final disease or condition a Gun shot wound to the head	d		Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):			,
	Cxammer	L.	Sequentially list conditions, than be as a consequence of:  Due to for as a consequence of:			7 ears
	ted insit	Examiner	cause. Enter Underlying Cause (Disease or injury			years
o,	te be executed ysician and ie burial-transit	Exal	that initiated events resulting in death) Last Due to (or as a consequence of):			V
3760,		Ilcal	d			
89 X	tific ng p as	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy	Winds Ass	23d. Date of de	livery
Вох	death cer a attendir d for use	lciar	23b. Was decedent pregnant in the past 12 months? In the past 12 months? In the past 12 months? In the past 12 months? In the past 12 months? In the past 12 months? In the past 12 months? In the past 12 months? In the past 12 months? In the past 12 months? In the past 12 months are the past 12 mon		Month	Day Year
P.O.	that the de ned by the a detached f	hys	9 ☐ Unknown	22a Did taba	ann una nontributa tr	the cause of death?
Ś	Se Te Se	by	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Hupertension, Prostate hypertrophy	1 ☐ Yes		obably 4 Unknown
ord	w require baen si	eted	Hypertension, (rastate hypertite)	24a. Was an		utopsy findings available
Record	e la has je 2	Completed		autopsy performe	prior to death?	completion of cause of
Vital		e Co	25. Was case referred to medical 26. Place of D	1  Yes 2 eath Check onl one	⊈No 1 ☐ Yes	202110
$\leq$	90 10 77	To B	examiper?	Home 5 Presiden	ce 6 □Other (Spe	cify)
n of			27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of linjury at Work?	28d. Describe how		
sio	ri Attendirig Phy er death. rector: After thi	cati	2   Accident 3   Suicide 3   Suicide 2   Accident 3   Suicide 3   Suicide 3   Suicide 3   Suicide 4   Suicide 5   Suicide 5   Suicide 6   Suicide   Suicide 6   Suicide   Suicid		ed gunshol	ural Route Number, My
Division	or A fiter Direction by	Certification:	4 Homicide determined building, etc. (Specify)	City or Town,	State)	or Dr. Colubia
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	alc	29a. Certifier (Check only (Ch	ce, and due to the cau	use(s) and manner as	s stated.
	he Ho in 24 in Fu pletel	ledical	(Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death oc and manner stated.		d. Date signed (Mont	Maria de la Caración
	To the within 2 To the complet	M				
1	15/11		30. Name and address of pelson who completed carse of death (Item 23a) (Type, Print)	thiut Caty		_ /
6	2(1)		PATTERCE A. TOYS, MD 4565 Hembole Conelly E	thirt Caty	MN ZIOF	2
		ate	31. Date filed (Month, Day, Year)  32. Registrar's Signature			
4	Regist		DEC 1 0 2004 Since 19			
υŀ	HMH 17 Rev 1/3	2001	ORIGINAL			

			1 - State Registrar AMEND TYPEM	State of M	-					and M	, ,	00	04	39197
П	Physici	an	1. Decedent's Name (1 iist, wilddie, Las.	0							2. Date of Deat Month	h Day	Year	3. Time of Death
	/Medio		Anna M. Warn  4a. Facility Name (If not institution, give		-}		4h Cih	Tours or	Location o	f Dogth	Detember		2004	
	Examir	ier		th Gre	/		-			n Deam		4c. Count	y of Death	
	Funeral		5. Social Security Number 6. Se	7. A	ge (In yrs. I	last birthday)	If Under		If Under :		8. Date of Birth	Mar A	9. Birth	place (State or Foreign
	Director		220-03-8807	⊒M 2 <u>√</u> ДГ	85	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, Jan. 28	, 1919	Mary	land
	put		Usual Residence of Decedent  10a. State 10b. County		100 Cit	y, Town or Lo	action							
	Aaryla I sho	ō			Too. Oily									10d. Inside City Limits 1 ☐ Yes 2 No
	the A	Directo	Maryland Baltimo	re		Cat	onsvi				1	0g. Citizen of	What Cou	
	3a or		5741 Edmondson	Avenue				2122	8		,	_	S.A.	iloy?
	72 hours after death with the Maryland natural; or ttems 23a or 28a-1 show dical Examinar must be notified at	Funeral	11. Marital Status	12. Was Decedent	Ever in U.	S. 13.				gin? (Spe	ecify Yes or No- Rican, etc.)	14. Ra	ce - Ameri	can Indian,
9	after or Ite	E/	1 Never Married 2 Married	Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give			irres,spec 1 □ Yes 2		n, mexican Specify:	, Puerto	Hican, etc.)		ick, White,	etc.
21215-0036	hours ural',	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:								Speci	w: W	hite
7	"nat	Completed	15. Decedent's Edi (Specify only highest grad			16a. Deced	dent's Usua kind of wor DO NOT us	l Occupa k done d	ition <i>uring m</i> ost	of worki	ing	16b. Kind of E	Business/Ir	ndustry
12	withi iene. than	шo	Elementary/Secondary (0·12)	College (1-4or	5+)		tress	9 19(1190)				F	ood	
	e filed I Hyg other	Be C	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle, N			
<u>Ja</u>	uld be Venta rrked rifc ev	To E	Ferdinand Truffe	r					Mary	Eli	zabeth l	Burns		
Maryland	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artment of Heatth and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-1 show injury or other traumatic event, Ilts Medical Examiner must be notified at 8.		19a. Informant's Name/Relationship (T)	ype, Print)		19b. Mailir	ng Address	(Street a	nd Numbe	r or Rura	il Route Number,	City or Town	, State, Zij	Code)
2	and lealth m 27 her tr		Anna Warner (Dau	ghter)	201 21	8682	-		arbou		asadena			
Baltimore,	ges 1 It of H If ite or otl	1 3	20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	CE	lace of Dispo emetery, cren	natory or ot	her place				20c. Location	- City or T	own, State
計	it. Pa rtmer rtant: njury		* 4 □ Donation 5 □ Other (Specify,		Lou	idon Pa								Maryland
Ba	permit. Page Department i important: If any injury or once.	ii.	21. Signature of Funeral Service Licens	22-	70081	- 1 I	530 E	dmon	dson	Aven	of Cato	nsville	le, I e, MD	nc. 21228
			thock, or heart allure. List only o	lications that cause ne cause on each l	d the death line.	i. Do not ent	er the mode	of dying	, such as o	cardiac c	r respiratory arre	st,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Pheim	enia									weeks
	Examiner			Due to (or as	s a consequ	uence of):								
	1 1/2 1	Б	if any, leading to immediate	b. Due to (or as	a consequ	uence of):							-	
	outed d ansit	Examiner	Cause. Enter Underlying	С.										
oʻ	ate be executed hysician and the burial-transit	Exa	resulting in death) Last	Due to (or as	a consequ	ience of):								
8760,	cate be executed physician and the burial-transit	cal		d				_						
9	The law requires that the death certific tie has been signed by the attending p bage 2 should be detached for use as	Physician/Medical	IF FEMALE:	23c. If yes, outcome				TI TOTAL ST			_			
Box	that the death certific ed by the attending p detached for use as	lan	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	death 3	Ectopic pre						ite of delive	ery Day Year
o.	the de	nyslo	1 ☐ Yes 2 🖾 No 9 ☐ Unknown	9 Unknown	u ume or de	aui 3	Other (spe	GIIY)						
s, D	signed b		Part II. Other significant conditions co	ntributing to death t	out not resu	ılting in the ur	nderlying ca	use give	n in Part I.		23e. Did tob	acco use con	tribute to th	ne cause of death?
rds	w require: been sig should bo	Completed by	Acuk Myocard	al info	ucho	m					1 ☐ Ye	s 2 🗆 No	3 Prot	ably 4 Unknown
Vital Record	aw re	plet	Acuke Renal F	alure							24a. Was an	24b.	Were auto	psy findings available mpletion of cause of
ž		Com									autopsy perform 1 Yes 2	ed?	death?	mpletion of cause of 212 No
Ita	striffica ctor, I	Bec	25. Was case referred to medical examiner?						26. Place	of Death	(Check only one		7 - 7 - 7 - 7	
	hysic this ce	္	1 ☐ Yes 2 █ No	lospital: 1 🔀 Inpati		ER/Outpatien			4   1901	sing Hor	ne 5 🗆 Resider	nce 6 Oth	er (Specif	y)
Division of	Attending Physician: r death. ector: After this certifici by the funeral director,	lon:	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Inju (Month, Da	ay Year)	28b. Time of Injury		lc. Injury Work			8d. Describe how	v injury occur	red	
<u>s</u>	ttend death stor: ,	icat	2 Accident investigation 3 Suicide 6 Could not be	29a Pissa of In	ium. At hou	mo form star	M		es 2□N	-	Of Logotion (Ct-			10
<u>&gt;</u>	il or Attending Phy after death. I Director: After this d in by the funeral d	Certification:	4 Homicide determined	28e. Place of In building, e	tc. (Specify,	)	et, ractory,	опісе		2	28f. Location (Str. City or Town,	State)	er or Hura	I Houte Number,
	To the Hospital or within 24 hours afte To the Funeral Dirrocompletely filled in I	aC	29a. Certifier 1 Certifying Phy	sician: To the best	of my know	vledge, death	occurred a	t the time	e, date and	I place, a	ind due to the cai	use(s) and ma	anner as si	ated.
	ne Ho	edical	(Check only 2 Medicel Exami	ner: On the basis of and manner st	of examinati	ion and/or inv	estigation,	in my opi	nion, death	1 occurre	ed at the time, da	e and place,	and due to	the cause(s)
	To the within 2 To the complet	7	29b. Signature and title of certifier				29c.	License	number		29	d. Date signe	d (Month,	Day, Year)
_			Molammed	MD			P	1760	01		D	ecembe	, 0	7,2004
1	11		30. Name and address of person who co		death (Item		Print)							•
7	Sta	to	Noverse Mohammer 31. Date filed (Month, Day, Year)	32. Registr	Agne:					Bal	hmore,1	MD 2	1229	
	Registr	- 60	DEC 1 0 20	04 Be.	نعمي	4	Lo							
							- Alle	1.43	7					

			1 - For State Registrar	State of M	larylan		artmen rtificat				Reg. No	004	391	98
ı	Physici	an	Decedent's Name (First, Middle     Nonn T C		ırıcdı	-DC				2. Date of De Month DECEMBE	Dav	2004 Year	3. Time of 12:22	
			MORRIS  4a. Facility Name (If not institution		EISBE	:Ku	4b. City,	Town, or	Location of Deat			ounty of Deat		Ам
	Vital Records, P.O. Box sicien: The law requires that the death cert certificate has been signed by the attendin irector, page 2 should be detached for use		HOSPICE OF BAL			CTR.			TOWSO	N		BALT	IMORE	
			5. Social Security Number 206-10-5095	6. Sex 7. Aq 1	ge (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da SEP.21	h y, Year)	9. Birti Co	hplace (State o	or Foreign
	ט		Usual Residence of Decedent							3LP.21	,1914		MI	,
	Aarylar f ehow	ō	10a. State 10b. County	N/A	10c. Cit	y, Town or Lo BALTI							10d. Inside C	-
	or 28a-	by Funeral Director	10e. Street and Number	IV/A	1.,	DALII	10f. Zip	Code			10g. Citize	n of What Co	^	
	ath wil	ralD	7386 PARK HEI	IGHTS AVENUE					21208			USA		
	fter de r Items	Fune	11. Marital Status 1 □ Never Married 2 🛣 Mar	12. Was Decedent Armed Forces' rried 1 X Yes 2 1	?	S. 13.	Was Deced f Yes, spec	lent of Hi cify Cubar	spanic Origin? (S n, Mexican, Puert	pecify Yes or No to Rican, etc.)	. 14	. Race - Ame Black, White		
3036	ours a	d by	3 ☐ Widowed 4 ☐ Divorced				1 ☐ Yes 2	21X No	Specify:		S	pecify:	WHITE	<u>:</u>
15-(	in 72 h "natu	letec	(Specify only highe	nt's Education est grade completed)		16a. Dece (Give	dent's Usua kind of wor DO NOT us	k done d	luring most of wor	rking	16b. Kind	of Business/	Industry	
212	d withi	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	SALES					REST	AURANT	SUPPL1	ES
and	i be file ntal Hy ed oth	Be	17. Father's Name (First, Middle, BENJAMIN	Last)		LIETCD	EDC			ne (First, Middle,	Maiden Si	•	ONCON	
aryla	should nd Mer mark umatic	ဥ	DENUAMIN  19a. Informant's Name/Relations	ship (Type, Print)		WEISB 19b. Mailir		(Street a	SARAH nd Number or Ru	ıral Route Numbe	ar, City or 7		ONSON Zip Code)	
	and 2 ealth a n 27 ls		DORIS WEISBER	RG / WIFE					GHTS AVE	ENUE - B	ALTIM	ORE, M	D 21208	}
Jore	ages 1 nt of He t: If iten / or oth		20a. Method of Disposition 1 ABurial 2 Cremation			lace of Dispo emetery, crer	natory or of	ther place	·	Date		tion - City or		4D
atin	mit. Parantmei sortant rinjury		* 4 □ Donation 5 □ Other (S	P 1-1-1	MD	VETERA 22				09/2004 DL LEVIN			ILLS, M	טו
ä	Per Special Property of the pr		Millial	Trug	er	8	900 R	EIST	ERSTOWN	ROAD - 1	PIKES			208
			23a. Part 1. Enter the disease, or shock, or heart failure. List	r complications that cause t only one cause in each I	ine.			e of dying	, such as cardiad	or respiratory ar	rest,		Approximate Interval Better Onset and I	ween
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as		IOMYOP	ATHY						YEARS	
	Examiner		Sequentially list conditions,	b	ISC	HEMIC	HEART	DIS	EASE				YEARS	
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as	Dive to (unas a consequence of):									
0,	execu an and rial-tra	Exar	that initiated events resulting in death) Last	cDue to (or as	a consequ	uence of):								
	ate be	dical		d		· · · · · · · · · · · · · · · · · · ·								
9 X	certific nding puse as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			-				230	d. Date of deli	VADV	
	0 0 0	siciai	in the past 12 months? 1 □ Yes 2 □ No	1☐Live birth 4☐Pregnant a 9☐Unknown			Ectopic pro Other <i>(sp</i> e					Month	*	/ear
<u>α</u>	that the	Phy	9 ☐ Unknown  Part II. Other significant conditi		out not resu	ulting in the ur	nderlying ca	IIISA NIVA	n in Part I	23e. Did to	obacco use	contribute to	the cause of d	eath?
rds,	n sign	ed by	ACUTE RENAL							1 <b>X</b> Y			obably 4 🗆 U	
eco	law rea	Completed	HYPERTENSION							24a. Was		24b. Were aut	topsy findings a	available
a B	The ate		HYPERLIPIDEM								med?	death?	_	1230 01
	/siciar s certif	To Be	25. Was case referred to medica examiner?  1 Yes 2 No	Hospital:	ent 2 🗆	ER/Outpatien	t 3 DO	Δ Othe		th <i>Check onl</i> o		Other (Spec	HOSPI	CE
n of	를 끌 등		27. Manner of Death  1 Natural 5 Pendir	28a. Date of Inju		28b. Time of Injury		Bc. Injury Work		28d. Describe h			y)=====	
Division	vttendi death. ctor: A y the fu	licati	2 Accident investi	not be 200 Block of In	iury - At ho	me farm str	M ant factory		es 2 □No	28f. Location (S	itreet and h	Jumbar or Ru	ral Pouto Num	her
Ö	i Dir a	Certification:	4 Homicide determ	building, e	tc. (Specify	')	Joi, Idolory	, 0,11100		City or Tow	n, State)		a route runn	201,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical (	Check only 2 Medicel	ng Physicien: To the best Examiner: On the basis of	of examinal	wledge, death	occurred a	at the time in my op	e, date and place inion, death occu	, and due to the o	ause(s) and pl	d manner as ace, and due	stated. to the cause(s)	)
	To the within 2. To the Complet	Med	29b. Signature and title of certifie	and manner st	tated.	01	29c	License				igned (Month		
)	> F 0		Navel B	Hel Atter	nding	Thysicio	41 D	00574	<b>4</b> 59		DECEN	IBER 4,	2004	
	7		30. Name and address of person					TUR	CON MAD	VI AND 21	204			
	Sta	te	DAVID BEKELMA  31. Date filed (Month, Day, Year)	)_ 32. Registi	rar's Signa	ture		A 41700	3-	ILAND ZI	204			
	Registr	ar	DEC 1	0 2004	ender	1	19	PORA	20					

			4 101	epartment of Health and M	-	ne
			Registrar	Certificate of Death		NZUU4 39/99
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  ELizabeth L Whit	e	2. Date of Death Month Decombon	Day Year 11 30 4M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			Spa Creek CTr	ANNAPULIS MD		ArmoArurdeL
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthe	Months Days Hours Min	8. Date of Birth (Month, Day, Ye	
	Director	ļ	Usual Residence of Decedent		OCT. 3, 1	915 Maryland
	/land		10a. State 10b. County 10c. City, Town of	or Location		10d. Inside City Limits
	Man Hed	ţ	MD Anne Arundel Hanover			1 ☐ Yes a No
	r 28s	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	be filed within 72 hours after death with the Maryland hal Hygiene. Id other than "natural", or liems 23a or 28a-f show event, the Medical Examinar must be notified at	aiD	1384 Hanover Road	21076		USA
	dea	by Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - American Indian, Black, White, etc.
98	or It	교	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 ☑ No Specify:	7.1.52.1, 515.7	
Ö	ural',	d b	3 Year or Dates:			willce
21215-0036	n 72	Completed	15. Decedent's Education (Specify only highest grade completed) ((	ecedent's Usual Occupation Give kind of work done during most of work ife. DO NOT use retired)	king	b. Kind of Business/Industry
12	withii lene. than	m.	Elementary/Secondary (0-12) College (1-4or 5+)			O T T T
	filed Hygid other ent, I		17. Father's Name (First, Middle, Last)	Homemaker  18. Mother's Nam	ie (First, Middle, Maid	Own Home  den Sumame)
an		To Be	George Hack	Lydia (	Combs	
Maryland	E D E E	-	19a. Informant's Name/Relationship (Type, Print) 19b. N	Mailing Address (Street and Number or Run		ity or Town, State, Zip Code)
			Carolyn Sacker - daughter 79	969 Crowns Way, Gler	Burnie,	MD 21061
ē,	s 1 a of Hei item		20a. Method of Disposition 20b. Place of Disposition			Location - City or Town, State
Ë	Pages nent of int: If it				3/2004 B	altimore, MD
Baltimore,	글 든 뿐 글 .		21. Signature of Funeral Service Licensee	22. Name and Address of Facility		
œ	Depa Depa Impo any is		11KV. Hademan	7250 Washington Bly	meral Home Md. Elkri	@ Meadowridge MP, Inc.
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or hear failure. List only one cause on each line.	t enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
	Physician	Si (	La company of the com		· to chew	
4	/Medical		resulting in death)  a.  Due to (or as a consequence of)	A THE STATE OF THE	7	a we
	Examiner		Sequentially list conditions.			
	Sit ad	inei	Sequentially list conditions, if any, leading to immediate cause. Each of Jerring Cause (Disease or injury	:		
	ate be executed hysician and he burial-transit	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of)			
760,	be ey	caiE	330 10 (0) 43 4 64 105 455 105 37	•		
687	leath certificate b attending physic		d			r r
×	certif Iding	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
Вох	atter I for u	ciar	23b. Was decedent pregnant in the past 12 months?  1  Yes 2	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year
0	at the de by the a tached	hysi	9 Unknown			
٦	The law requires that the death certifica sie has been signed by the attending ph page 2 should be detached for use as th	by PI	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
rds	w require been sig should b	pe pe			1 ☐ Yes	2 76 3 Probably 4 Unknown
၀	s bee	plet			24a. Was an	24b. Were autopsy findings available
Vital Records,	The lav	Completed		,	autopsy performed	prior to completion of cause of death?
ital		a	25. Was case referred to medical	26. Place of Deat	h (Check only one)	
<b>\</b>	g : 5	To B	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp:	atient 3 DOA Other: 4 Hursing Ho	ome 5 🗆 Residence	6 ☐Other (Specify)
n of	ding Ph h. After th funeral		27. Manner of Death 28a. Date of Injury 28b. Time (Month, Day Year) 28b. Time (Month, Day Year) 28b. Time (Month, Day Year)		28d. Describe how in	njury occurred
Ö	Attending in death.	atic	2 Accident investigation	M 1 ☐ Yes 2 ☐ No		
Division	l or Att after de Direct	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, late)
	ral D					
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only only only)  20 Medical Exeminer: On the best of my knowledge, only only only only only only only only	leath occurred at the time, date and place, or investigation, in my opinion, death occur	and due to the cause red at the time, date :	e(s) and manner as stated. and place, and due to the cause(s)
	thin 2 the the mple	Med	and manner stated.  29b. Signature and title of certifler	29c. License number	29d	Date signed (Month, Day, Year)
1	To To com		Man and P	1554 51		12/8/2004
6	2		30. Name and address of person who completed cause of death (Item 23a) (Ty	roe Print).		
1	1		Com J Some 2/1/8	D. Jonah Drive	Charter	12/8/2004 MD 2/6/9
	Sta		31. Date filed (Mont Pay Year) 200 37 Registrar's Signature	1		
	Registr	ar	2004 Booken &	morke		

			State of Ma	aryland		ment of Hea		ental Hy	giene,	101	00000
			State Registrar		Certi	icate of De	ath		Reg. No.	104	39200
	Physic	ian	Decedent's Name (First, Middle, Last)					2. Date of De. Month	ath Day/	Year /	3. Time of Death
	/Medi		Lillian L. Weber					12	04	04	0146 am.
	Exami	ner	4a. Facility Name (If not institution, give street and number)	/ da	4	. City, Town, or Loc	ation of Death	An il		ty of Death	
	Funeral	~	5. Social Security Number 6. Sex 7. Age	e (In yrs. las	t birthday)	Under 1 Year If U	Under 24 Hrs.	8. Date of Birt			1 (0: 1 :
	Director	Н	1 M 2 XE	33	Yrs.			(Month, Da 09/23/	y, <i>Year)</i>	Goun:	elace (State or Foreign ntry) vland
	P .		Usual Residence of Decedent	,,,				09/23/	1921	Mar	yrand
	arylar	-	10a. State 10b. County	10c. City, T	Town or Locati	on				10	0d. Inside City Limits
	Ba-f	cto	MD Baltimore	Cato	nsville	9					1 ☐ Yes 2 ☐ No
	with th	Director	10e. Street and Number		1	Of. Zip Code			10g. Citizen of	What Count	try?
	death with the Maryland ms 23a or 28a-f ehow	rai	11 Sanford Avenue			21228			USA		
-	P 2 3	Funerai	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  1 □ Yes 2 ☒ N.		13. Was	Decedent of Hispan s, specify Cuban, Me	iic Origin? (Spec exican, Puerto R	ify Yes or No- ican, etc.)		ce - America	
36	irs af	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒N. 3 ☒ Widowed 4 ☐ Divorced Year or Dates;	0	10	Yes 2⊠ No Sp	ecity:			∜: Whit	
21215-0036	within 72 hours after ene. than "natural", or Ita		15. Decedent's Education		16a. Decedent	s Usual Occupation					
215		Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5-4)		(Give kind life. DQ	of work done during IOT use retired)	g most of working	7	16b. Kind of E	usinessying	Justry
	giene giene er tha	on	12 n/a	" !	homemal	er			domes	tic	
pu	al Hy al Hy al oth	Be (	17. Father's Name (First, Middle, Last)				Mother's Name (			ne)	
<u>a</u>	Ment Ment arke	2	Henry Cochran				Henriet	ta Spei	ncer		
Maryland	12 should be filed within h and Mental Hygiene. 7 le marked other than " raumatic evant, II a Mar		19a. Informant's Name/Relationship (Type, Print)	14:	19b. Mailing A	idress (Street and N	lumber or Rural I	Route Numbe	r, City or Town	State, Zip (	Code)
	8 = 2 -		Darlene Jarmans-daughter			ord Ave.,	Baltim	ore, M	21228		
Baltimore,			20a. Method of Disposition  X□ Burial 2 □ Cremation 3 □ Removal from State	Moad	e of Dispositio	y or other place)	Dat	te	20c. Location	· City or Tow	vn, State
ŧΪ	t. Pa rtmer rtant		* 4 ☐ Donation 5 ☐ Other (Specify)	Memo	rial Pa	rk	12/08	/2004 1	Elkridg	e, MD	
Ba	permit. Page Department of Important: If any Injury or		21. Signature of Funeral Service Licensee		Gary	me and Address of F L. Kaufma	Facility In Funer	al Home	e at Me	adowr:	idge Mem.Pk
		-	23a Part 1 Enter the disease or complications that caused to	the death. [	1250	wasningto	on Blva.	, Elkr	idae, M	D 2107	75
	2000		23a. Part1. Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each line Immediate Cause (Final	).	20 Not enter th	a mode or dying, suc	ch as cardiac or i	espiratory arr	est,	ı	Approximate Interval Between Onset and Death_
	Pnysician /Medical		disease or condition resulting in death)	myor	cardio	Linfar	ction				30 minutes
	Examiner		Due to (or as a	0			,	4			
		ē	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that stitute was or injury	consequen	ce of):	-diovascu	lar dis	ease		- (	c years
	be executed sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events		•						
ó	execan an an rial-tr	Еха	resulting in death) Last Due to (or as a	consequent	ce of):		·				
68760,	fficate be executed g physician and as the burial-transit	edical	d								
99	rtificate ng phy s as the	Med	IF FEMALE:				-				
300	death certifi e attending I d for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?			pic pregnancy			23d. Dat	te of delivery	у
0.0	0 00	/slci	1 Yes 2 No 4 Pregnant at ti			er (specify)			Mo	nth D	Day Year
P. 9.	The law requires that the di Ite has been signed by the page 2 should be detached		Part II. Other significant conditions contributing to death but	not recultin	a in the undert			00 5:11			
ds,	signed d be de	d by	- Control of the cont	HOL LOSUKIN	g ar the drigen	ang cause given in F	чап I.				cause of death?
~ ö	w requir	etec							s 2 No	3 Probab	bly 400 Unknown
le be v	The lavate has	Completed						24a. Was as autops	y	prior to comp	sy findings available pletion of cause of
be al Re		မ င်	25 Was associated by said at					perform 1 Yes 2		leath?	□ No
₹ 5	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient			Other	Place of Death (C				
5	ding Phys h. After this funeral di	$\vdash$	27. Manner of Death 28a. Date of Injury (Month, Day)		Outpatient 3	28c. Injury at	Nursing Home		nce 6 □Othe w injury occurr		
ion	Attanding F r death. actor: After by the funer	atlo	1 Natural 5 Pending (Month, Day 1 2 Accident investigation	rear)	Injury N	Work?			injury coodin	30	
Division	Attane ar death ractor: by the	tific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	y - At home,	farm, street, f	actory, office	28f.	Location (Str	eet and Numbe	er or Rural F	Route Number,
D	tal or rs afte al Dir	Certification:	4 Homicide building, etc.	(Specify)				City or Town	State)		
	ne Hospital or Attandi 124 hours after death 1e Funeral Diractor: A bletely filled in by the t		29a. Certifier (Check only)  Medical Examiner: On the basis of or	my knowled	ige, death occi	rred at the time, dat	e and place, and	due to the ca	use(s) and mai	nner as state	ed.
	To the Hospital or Al within 24 hours after of To the Funeral Dirac completely filled in by	Medical	one) and manner state	id.	anwor investig						
	To vit	~	29b. Signature and title of certifier			29c. License numb	per	29	d. Date signed	(Month, Da	ly, Year)
	0	-	Chemi & / dry Oli mo			D2264	F	0	ecembe	2r 04.	2004
	N.D.		30. Name and address of person who completed cause of dea							11	
	Stat	e	31. Date filed (Month, Day, Year) 32. Redistrar's	s Signature		we Baltin	nure, m	ARYLAN	10 212	28	
	Registra	ar	31. Date filed (Month, Day, Year)  DEC 1 0 2004  32. Registrar's	w d	K Son	de					
	in a s					541					

			State of Maryland / Dep State of Maryland / Dep State of Maryland / Dep	artment of Health and Natificate of Death	Mental Hygier		39201					
	Physicia	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month	)av Year	3. Time of Death					
	/Medic	al	JAMES HENRY WATKINS SR	4b. City, Town, or Location of Death	DECEMBER	1,2004 4c. County of Death	10am ™					
	Examin	er	4a. Facility Name (If not institution, give street and number)  5818 PIMLICO RD.	BALTIMORE		n/a						
Ī	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 218-14-508 8 1 1	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth Month, Day, Yea 4-26-19	9. Birth	place (State or Foreign ntry)					
	ס		Usual Residence of Decedent				10d. Inside City Limits					
	Aarylau I show	ō	10a. State 10b. County 10c. City, Town or L BALTIM				1 XYes 2 ☐ No					
	r 28e-	Director	10e. Street and Number	10f. Zip Code	10g. (	Citizen of What Cou	ntry?					
	th with	aiD	5818 PIMLICO RD.	21209		USA						
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28e-f show or other traumatic event, the Madical Exam ser must be notified at or other traumatic event, the Madical Exam ser must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent Ever in U.S. Armed Forces?  14. Was Decedent Ever in U.S. Armed Forces?  15. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 🌠 No Specify:	pecify Yes or No- pecify Yes or No- pecify Record	14. Race - Ameri- Black, White, Specify: BLA	etc.					
8	2 hou	ted t	15. Decedent's Education 16a. Dece	edent's Usual Occupation a kind of work done during most of wor	ting 16b.	Kind of Business/In	dustry					
215	ithin 7 ne. "nar"n	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		W ENFOR	TEMENT					
22	filed w Hygier ther th		17. Father's Name (First, Middle, Last)	LICE OFFICER  18. Mother's Nan	ne (First, Middle, Maid		EMENI					
aryland 21215-0036	Aental riked o	To Be	JAMES WATKINS		ECCA WATK							
lary	2 sho and h is ma		111111111111111111111111111111111111111	ing Address (Street and Number or Ru								
e, S	1 and Health em 27 ther ti		20a Method of Disposition 20b. Place of Disp	8 PIMLICO RD. F		Location - City or To						
Itimore,	Pages nent of int: If it		1 VBurial 2 Cremation 3 Removal from State	matory or other place) MEMORIAL 12-6	5-2004 BA	LTIMORE	, MD					
a	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Eural Service/Licensee	2. Name and Address of Facility $\stackrel{\circ}{\mathrm{RI}}$	EDD FUNER	AL SERV	CE					
m_	50E 5 8		7.5	1721-27 N. MONE		ALTO.MD						
			23a. Part 1. Enfer the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.  Immediate Gause (Final	political			Approximate Interval Between Onset and Death					
	Physician / /Medical		disease or condition resulting in death)  a.   Congest-ee Heart tarlung  Due to (or as a consequence of):									
ı	Examiner		Sequentially list conditions b									
./	ed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
V1	execut n and ial-trar	Exan	that initiated events c. resulting in death) Last Due to (or as a consequence of):									
8760, -	icate be executed physician and s the burial-transit	dicail	d									
9	ertifica ling ph e as th	Med	IF FEMALE:									
P.O. Box	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as:	by Physician/Me		□ Ectopic pregnancy □ Other (specify)		23d. Date of deliv Month	ery Day Year					
	ires that signed by d be deta	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	./	o use contribute to t	he cause of death?					
COL	w require s been si should b	Completed	6 - 20		24a. Was an	24b. Were auto	ppsy findings available					
æ	The lav	omi	Vascular Miserie		autopsy performed? 1 ☐ Yes 2 ☑	? death?	mpletion of cause of					
/ita	ysician: The lis certificate hadirector, page	Be	25. Was case referred to medical examiner?	Other	th (Check only one)							
of	Physic rthis or ral dir	T.	1 ☐ Yes 28 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie  27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	ome Residence 28d. Describe how in		(y)					
on	nding ath. r: Afte e fune	atior	1 Statural 5 □ Pending (Month, Ďaý Year) Injury 2 □ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No								
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, Sta		al Route Number,					
	spital o		29a. Certifier 1 Sertifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place	, and due to the cause	(s) and manner as s	tated.					
	n 24 h n 24 h he Fur pletely	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occu	rred at the time, date a	and place, and due t	o the cause(s)					
	withi To th	Σ	29b. Signature and title of certifier	29c. License number	29d. [	Date signed (Month,	Day, Year)					
,	11		20. Name and address of payees who completed course of death //www.co.i.d.	Print		5/5/0,	1					
	2511		30. Name and address of person who completed cause of death (Item 23a) (Type Completed Cause of July Cause of July Completed Cause of July Cause of Ju		SX i	Sultra	e No					
	Sta Regist		DEC 1 0 2004 Server &	South								

1 - For State Registrar

10a State

5. Social Security Number

067-26-3174

Usual Residence of Decedent

**Physician** 

/Medical

Examiner

**Funeral** 

Director

1. Decedent's Name (First, Middle, Last)

JONAS ZUKAS

4a. Fecility Name (If not institution, give street and number)

10b. County

Greater Baltimore Medical Center

1 M M 2 □ F

KAS, JONA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Towson

Days

7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

10c. City, Town or Location

Certificate of Death

4b. City, Town, or Location of Death

2. Date of Death Month Day December 8,

8. Date of Birth (Month, Day, Year) 11/12/1907

2004

LITHUANIA

4c. County of Death

Baltimore

8:30

Birthplace (State or Foreign Country)

10d. Inside City Limits

	ľ	1- For State of Maryland / Department of Health and Certificate of Death		Rag. No	2004	39203
Physici /Medic		1. Decedent's Name (First, Middle, Last)  Marion A. Zimmerman	2. Date of D Month Dec.	eath Da	Year 2004	3. Time of Death 4:35A
Examin Funeral	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  Carroll County Gen. Hospital Westminster  5. Social Security Number  6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of B	irth	Carro 9. Birth	place (State or Foreign
Director		213-03-7517 1 M AFF 91 Yrs. Months Days Hours Min.  Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	Nov.3	0,1	913 Mar	yland  10d. Inside City Limits
he Maryla 28a-f ahor	ector	MD Carroll Finksburg		10- 0	itizen of What Cou	1 ☐ Yes 🔏 🙀 No
23s. or 2	Funeral Director	634 Ridge Rd. 21048			U.S.A.	ntry?
1215-U036 within 72 hours after death with the Maryland ane. than "natural", or Items 23c or 28e-f ahow than "natural" or Items 23c or 28e-f ahow are register in the fredised at the second of the se	by	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Yes ★★ No If Yes, Give Year or Dates:  1 □ Yes ★★ No Specify:	pecify Yes or N to Rican, etc.)	0-	14. Race - Ameri Black, White, Specify:	
1215-0036 within 72 hours aft ane. than "natural, or than Evani	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of work if the DO NOT use retired)  Homemaker	rking	16b. ł	Cind of Business/In	
be filed tal Hygin of other	To Be Co	17. Father's Name (First, Middle, Last)  18. Mother's Nam	me (First, Middle		Own F	iome
Maryla d 2 should th and Men T la marke traumatic		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ru	ıral Route Numi	ber, City		
Baltimore, I permit. Pages 1 and Department of Healt Important: If item 2: any injury or other?		Madeline K. Jones / Daughter 1518 Deer Park Rd.  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Name and Address of Facility Economics  21. Signature of Euperal Service Licensee  22. Name and Address of Facility Economics  21. Signature of Euperal Service Licensee  22. Name and Address of Facility Economics  23. Name and Address of Facility Economics  24. Name and Address of Facility Economics  25. Name and Address of Facility Economics  26. Name and Address of Facility Economics  27. Name and Address of Facility Economics  28. Name and Address of Facility Economics  29. Name and Address of Facility Economics  20c. Name and Address of Facility Econ	Date 12/11/ khardt	04 ] Fur	ocation - City or To Finksbu: neral Ch	rg,MD apel P.A.
Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	or respiratory		igs mili	Approximate Interval Between Onset and Death
/Medical reate be executed buysician and buysician and street buriar-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  ACUTE MYC CARD) AZ IN  Due to (or as a consequence of):	FARC	ПО	N	2 days
Hecords, P.O. Box 68/ The law requires that the death certificate ate has been signed by the attending phys bage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1			23d. Date of delive Month	ery Day Year
rdS, P. quires that t n signed by	by	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.		tobacco	use contribute to the	ne cause of death?
	Completed		24a. Wa. auto perf 1 Yes		prior to co death?	psy findings available mpletion of cause of 2 No
Of VITAL Ke Physician: The This certificate hirral director, page	To Be	25. Was case referred to medical examiner?  1  Yes 2 No			6 ☐Other (Specif	v)
ding ding Afte fune		27. Manner of Death 1. ✓ Natural 5 ☐ Pending 2 ☐ Accident	28d. Describe			
DIVISION To the Hospital or Attentivition 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or To	own, Stat		
To the Hospital or within 24 hours afte To the 5-uneral Dir completely filled in	Medical	29a. Certifier  (Check only one)  1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place to make the control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place to make the control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place to make the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place to make the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place to make the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place to make the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place to make the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place to make the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place the basis of examination and/or investigation, in my opinion, death occurred at the basis of examination and death occurred at the basis of examination and death occurred at the basis of examination and death occurred at the basis of examination and death occurred at the basis of examination and death occurred at the basis of examination and death occurred at the basis of examination and death occurred at the basis of examination and death occurred at the basis of examination and death occurred at the basis of examination and death occurred at the basis of examination and death occurred at the basis of examination and death occurred at the basis of examination and death occurred at the basis of examination at the basis of examination at the basis of examinati				
To th within To th comp	) )	29b. Signature and title of certifier  DO018200	2	1	ate signed (Month, 9-7-0 4	
HIL		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  CHITRACHEDU NACANNA MD 700 A poole Rd WEST	MWSTE	EN	MD 2	.1157
Sta Registi		31. Date filed (Most Day Year) 2004 32. Registrar's Signature				
DHMH 17 Rev 1/2	001	ORIGINAL ORIGINAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Date of Death 1. Decedent's Name (First, Middle, Last) De Cempor 12:10 A.M. **Physician** 2004 Theodore Frank Zaworski /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** North Arundel Hospital Glen Burnie Anne Arunde1 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 GM 2 □ F 85 Yrs. 213-01-6162 4/10/1919 **Director** Maryland Usual Residence of Decedent 10a. State 10d. Inside City Limits 10c. City. Town or Location 10b. County item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, its Medical Event and must be notified at 1 ☐ Yes 2X No MD Pasadena Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8347 Forest Drive 21122 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Specify: þ 3 Widowed 4 Divorced nd Mental Hygiene. marked other than "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pipe Fitter Bethlehem STeel 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental H Marie Kacziski Frank Zaworski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type Print) permit. Pages 1 and 2 shall Department of Health and Important: If item 27 is m (Daughter) 8347 Forest Drive Pasadena, Maryland 21122 Joyce Muir Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State any injury or 12/6/04 Oak Lawn Cemetery Balitmore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Charles S. Zeiler & Son, Inc. 1 ans 6224 Fastern Avenue Baltimore, MD 21224 Approximate Interval Between Onset and Death 23a. Part1. End, the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory street, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition cos **Physician** resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or all a consequence of) Physician/Medical Examiner use as the burial-transit The law requires that the death certificate be executed ownan Due to (or as a consequence of P.O. Box 68760. the attending physician IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death 1 Live birth in the past 12 months?
1 Yes 2 No Month Day Year jo 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s autonsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Depatient 1 Yes 2 ER/Outpatient 3□ DOA funeral dir Medical Certification: To 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Natural 2 Accident Injury 5 Pending 1 Tes 2 No investigation after death 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 Homicide filled within 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only one)

the

200

State Registrar

DHMH 17 Rev 1/2001

31. Dale filed (Month, Day, Year) DEC 1 0 2004

29b. Signature and title of certified

Ayrika Over im Hospita 32. Registrar's Signature

ess of person who completed cause of death (Item 23a) (Type, Print)

301

**ORIGINAL** 

29c. License number

29d. Date signed (Month, Dey, Year)

		For State Registrar	State of M	Maryland / Dep Ce	partment of Fertificate of			giene 0	04	39205
	я	Decedent's Name (First, Middle, I	last)	*			2. Date of Dea		Vee	3. Time of Death
Physic /Medi		Priscilla	Louise	Abbott				er 25,	2004	11:00 A <sup>M</sup>
Exami	ner	4a. Facility Name (If not institution, g		ər)	4b. City, Town, o		ath		ly of Deeth	
	5.	1415 Riverside I 5. Social Security Number 6		Age (In yrs. last birthda	Salisbu	. 4	rs. A Date of Birt		omico	lace (State or Enraign
Funeral Director		216-44-7881	1□M 200F	60 Yrs.	Months Days		in. 8. Date of Birt (Month, Da			elece (State or Foreign entry) Land
2 >		Usual Residence of Decedent		10c. City, Town or I			007.017			
faryla shov	20	10a. State 10b. County							1	0d. Inside City Limits  1 Yes 2 □ No
the N 28a-f	Director	MD Wicomi	ico	Salish	10f. Zip Code			10g. Citizen of	What Coun	
death with the Maryland me 23a or 28a-f show rmust be notified at	i Di	1415 Riverside I	)rive		218	01		USA		,
ame 2	Funerai	11. Marital Status	12. Was Deceder	nt Ever in U.S. 13	. Was Decedent of H		(Specify Yes or No-	14. Ra	ce - Americ	
S afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ※ Divorced	1 ☐ Yes 2) If Yes, Give	No	1 ☐ Yes 2 No	Specify:	, , , , , , , , ,	Speci	ify:	
yland 21215-0036  uld be filed within 72 hours after Mental Hygiene.  arked other than "natural", or Ita  attic event, the Medical Examina	ed b	15. Decedent's	Year or Dates		edent's Usual Occup	ation		16b. Kind of 8	Whi Business/Ind	
215 Pin 72 Made in 72	Completed	(Specify only highest of Elementary/Secondary (0-12)		(Giv	e kind of work done of DO NOT use retired	during most of v	vorking			,
21.	Соп	12	none		<u>ebotemist</u>			Medica		
be fill doth	Be	17. Father's Name (First, Middle, La	st)				lame (First, Middle,		-,	
Maryland 21215-0036 d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene. 77 is marked other than "natural", or Itame 23a or 28a-1 show traumatic event, the Medical Examinar must be notified at	-C	Oscar Abbott 19a. Informant's Name/Relationship	(Tune Print)	19h Mai	ling Address (Street		s Margare			Cadal
M8		Dawn O'Neal/Daug								C000)
O - 1 2 2		20a. Method of Disposition		20b. Place of Disp	Rickover position (Name of ematory or other place		Date	20c. Location		wn, State
Pages nent of nnt: If its		1 Burial 2 Cremation 3 4 Donation 5 Other (Spe	☐Removal from State cify)	19	-	1	/30/2004	Deal Is	land.	Maryland
Baltimo permit. Page Department ( Importent: If any injury or	/	Signature of Foneral Solver bio	ensee	Н	22. Name and Addre	ss of Facility eral Ho	ne			integrating.
Physician /Medical	8	75a. Part 1. Enter the disease, or commediate Cause (Final disease or condition resulting in death)	a	gểd thể death. Do not e Tline.	1673 Some neer the mode of dyin	g, such as card	iac or respiratory ar	rest,	İ	ryland 218 Approximate Interval Between Onset and Death
Examiner			Due to (or a	as a consequence of):	Cama	_ 04	22.6			
\$ ·	ē	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that introduced to the cause to	b. Due to (or a	as a consequence of):	COLEIN	G-7 C-1	and mile	مو		
60, be executed sician and burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c							
8760, ate be exe hysician a the burial-		resulting in death) Last	Due to (or a	as a consequence of):						
687 ficate t	dicai		d							
death certi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown		2 Fetal death 3 at time of death 5	□Ectopic pregnancy □ Other (specify)				ate of delive onth	ry Day Year
<u> </u>		Part II. Other significant conditions	contributing to death	n but not resulting in the	underlying cause give	en in Part I.	23e. Did to	bacco use con	tribute to th	e cause of death?
Hecords, he law requires t e has been signe sge 2 should be o	ed by	Lupus, psy:	7.7 21DC	B			104	es 2□No	3 🗆 Proba	ably 4 Unknown
aw requir	Completed						24a. Was a			osy findings available
The law	E O		_				perfor		death?	npletion of cause of 2 \sum No
Vital I	Be (	25. Was case referred to medical examiner?	(1		200 = 11.		eath (Check only or	ne)		
this ald	2	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpa		7	4   Nursing	Home 5 3 sid			)
E e	tion	1 Natural 5 Pending 2 Accident investigat	28a. Date of Ir (Month, L	Day Year) Injury	Worl		28d. Describe II	ow injury occur	rea	
DIVISION I or Attending after death. Diractor: Alter	Certification;	3 Suicide 6 Could not	be 28e. Place of I	Injury - At home, farm, s			28f. Location (S		ber or Rural	Route Number,
S afte	Cert	4   Homicide	building,	etc. (Specify)			City or Tow	n, State)		
DIVISION To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edicai	29a. Certifier 1 Certifying (Check only one) 1 Medical Ex	Physician: To the be- aminer: On the basis and manner	st of my knowledge, dea s of examination and/or i stated.	ath occurred at the tin	ne, date and pla pinion, death oc	ce, and due to the c curred at the time, c	ause(s) and m late and place,	anner as sta and due to	ated. the cause(s)
To t To t	Σ	29b. Signature and title of certifier	0-03	M	29c. License		2	29d. Date signe		Day, Year)
		Theres	NA CONTRACTOR			0.2		11.53	,C4	
		30. Name and address of person who	. MD . 105	PUZ Brutt	Celebra	MOZIB	र ।			
St	ate	31. Date filed (Month, Day, Year)	32. Reg	Arar's Signature						
Regist	rar	DEC -	1 2004	sever to	bresh					

			1 - State Registrar	State of Marylar	•	ent of Health an		giene Reg. No 2004	39206
	Physic	ian	Decedent's Name (First, Middle, Last)				2. Date of Dea Month	Day Year	3. Time of Death
	/Medi Exami		Dorothy 4a. Facility Name (If not institution, give strength of the control of th	MUNICAL	. / -	City, Town, or Location of C		23 04 4c. County of Deat <i>MCOM</i>	h .
	Funeral Director		5. Social Security Number 6. Sec 214-46-4925	-		nder 1 Year If Under 24'	Hrs. 8. Date of Birth (Month, Day 04 / 15 / 1		hplace (State or Foreign buntry) nsylvania
	Maryland f show	or	Usual Residence of Decedent  10a. State 10b. County		ty, Town or Location				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	or 28a-	Director	MD Somers  10e. Street and Number	et Up	per Fairme	Oun t Zip Code		10g. Citizen of What Co	puntry?
(0	be filed within 72 hours after death with the Maryland stal Hygiene.  dother than "naturel", or items 23e or 28e-f show event. I're Modical Exerting mast be notified at		PO Box 104, Halls  11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 No		21867 ecedent of Hispanic Origin specify Cuban, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	USA 14. Race - Ame Black, White	
21215-0036		þ	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Edu (Specify only highest grade	If Yes, Give Year or Dates:	16a. Decedent's U	s and No Specify:  Jsual Occupation  work done during most of	workina	Specify: W	White
2121	d within giene. or than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Clerk	Tuse retired)		Convenien	re Store
mark.	should be filed within and Mental Hygiene. s marked other than umatic event, I're M	To Be C	17. Father's Name <i>(First, Middle, Last)</i> <b>unknown</b>				Name <i>(First, Middl</i> e, ara Heck		
Mary	2 8 8		19a. Informant's Name/Relationship (Ty Julie A. Thompson			ress <i>(Street and Number o</i> airmount Roa		-	
Baltimore,	Heali Heali tem 2		20a. Method of Disposition  1  Burial 2 Cremation 3  4 Donation 5 Other (Specify)	20b. Flemoval from State	Place of Disposition ( cemetery, crematory	Name of or other place)	Date	20c. Location - City or	Town, State
Baltin	permit. Pages Department of Importent: If i eny injury or once.	C	21 Signature of Funeral ervice/L ensi		22. Name Hinman	rematory   11 e and Address of Facility n Funeral Hon Somerset Av	me		
	rate be executed hysician and hysician and the burial-transit	al Examiner	23a. Part 1. Enter the disease, or comply shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, any, having to minural tate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	Due to (or as a consection of the course of	inence of):  As to	icpsid		rest,	Approximate Interval Between Onset and Death
.O. Box 687	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₹□ No 9 □ Unknown	23d. Date of deli Month	ivery Day Year				
rds, P	quires that n signed b uld be deta	by	Part II. Other significant conditions cor	ntributing to death but not res	sulting in the underlyin	ng cause given in Part I.	23e. Did to	bacco use contribute to	
		Completed					24a. Was a autop perfor 1 Yes	sy prior to a med? death?	topsy findings available completion of cause of
on of Vital	hyeic his ce Il direi	tlon: To Be	27. Manner of Death  1 Natural 5 Pending	12 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 28b. Time of Injury	Othor	7200	ne) ence 6 □Other (Spec ow injury occurred	cify)
Division	al or Attending P s after death. Il Director: After t id in by the funera	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specifi	ome, farm, street, fac		28f. Location (S City or Tow	treet and Number or Ru n, State)	ral Route Number,
	To the Hospital of within 24 hours at To the Funerel D completely filled it	Medical C	29a. Certifier 1 Certifying Physical Control 2 Medical Examination	sician: To the best of my knoner: On the basis of examina and manner stated.	owledge, death occur ation and/or investiga	red at the time, date and pition, in my opinion, death o	lace, and due to the coccurred at the time, o	ause(s) and manner as date and place, and due	stated. to the cause(s)
)	To the within To the Comp	×	29b. Signature and title of certifier  72. A TW			29c. License number 554807	2	Nov - 24,	*
_			30. Name and address of person who co	empleted cause of death (Iter	n 23a) (Type, Print) CAMUL S	t. SAlisburg	1 Md 21		· · · · · · · · · · · · · · · · · · ·
ľ	Sta Regist		31. Date filed (Month, Day, Year) DEC - 1	32. Regisfar's Signa 2004	ature	relle s			

State of Maryland / Department of Health and Mental Hygier [ ] [ ] 1 - State Registra Certificate of Death . Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death 1:53 An 1908mbe **Physician** Earl A. Anderson /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Georges Doctor's Hospital Lanham 8. Date of Birth (Month, Day, Yea Nov. 20, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** ). 1938 Days Min. Months Hours 1X M 2□ F Panama 071-32-4855 66 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural; or items 23a or 28a-1 show any injury opeother traumatic event, the Medical Examinant her additional angones. 10a. State 1 Yes 2 □ No Director Maryland Prince Georges Greenbelt 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7909 Mandan Road 20770 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married ☐Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced African American 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) Deputy Director Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Federal Highway Administration Federal Government 17 Father's Name (First Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Felix Anderson Emma Ogle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 7909 Mandan Road, Greenbelt, MD Jovanni Anderson Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory 11/30/04 5 Other (Specify) ⁴ 4 □ Donation Beltsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility McGuire Funeral Service 7400 Georgia Ave. N.W., Wash. D.C. 23a. Part1. Enter the disease, or complications that daysed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Embolus Pulmonary HRS disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): attending physician Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death e Hospital or Attanding Pi 24 hours after death. e Funaral Diractor: After ti 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Hanssm 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8118 6000 LICK 1HOMAS M. HAN 550N LANHAM MIS 30706 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 24 2004 Registrar

ANDERSON, Ear

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2001 39208 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year 2004 28 2:20 PM Julia Virginia Brindle
4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Manchester
If Under 24 Hrs. 8
Hours Min. Carroll Longview Nursing Home
5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Sept 29 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year Months 1 □ M 2 1 F 97 Yrs 1907 Maryland 214-09-1509 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2□No Maryland Carroll Manchester 10e Street and Number 10f Zin Code 10g Citizen of What Country? 3332 Main Street 21102 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Yes 2 ② No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify.White 1 ☐ Yes 2 No Specify: 3 □XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) C.P.A. Firm Bookeeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Jennings Ethel Wastler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) George Edward Martin (Son) 16754 Ridge Road Upperco, Maryland 21155 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State St. Luke's Episcopal 4 ☐ Donation 5 ☐ Other (Specify) 12/2/04 Brownsville Maryland Church Conetery dress of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. N. Hagerstown, Maryland 21742 Part T. Enter the disease, or complications that caused the shock, or hear failure. List only one cause on each Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

> use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown

> > 24b. Were autopsy findings available prior to completion of cause of death?

29d. Date signed (Month, Day, Year)

11-30-2004

Physician /Medical Examiner

Department of Health a Important: If itam 27 is any injury or other tree

Physician

/Medical

Examiner

Funeral

Director

r then "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at

Funeral Director

Completed by

Be

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0020

2 Completed å Cartification: To s efter des... aral Director: A'
(v filled in by th

or Attending Physician: The law requires that the death certificete be executed Division of Vital Records, P.O. Box 68760,

	21 7 12 101 102 11	- Offset and Dea								
Immediate Cause (Final disease or condition resulting in death)	. Hzheimer's dementic	7								
,	Due to (or as a consequence of):									
	b									
sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of).									
causé. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of):									
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I. $\lambda$	23b. Did tobacco use contribute to the cause of d								
		24a. Was an autopsy performed?  24b. Were autopsy find available prior to completion of caus of death?								
		1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 ☐ No								
25. Was case referred to medical examiner?	26. Place of Death	(Check only one)								
1 ☐ Yes 2.X No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Hom	ne 5 Residence 6 Other (Specify)								
27. Manner of Death  1. Natural 5 □ Pending 2 □ Accident investigat	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28c. Injury	8d. Describe how injury occurred								
3 ☐ Suicide 6 ☐ Could not determine		8f. Location (Street and Number or Rural Route Number City or Town, State)								
29a. Certifier 1 Certifying F	Physicien: To the best of my knowledge, death occurred at the time, date and place, a aminer: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	nd due to the cause(s) and manner as stated. d at the time, date and place, and due to the cause(s)								

To the Hospital of within 24 hours en To the Funeral D completely filled in the Funeral D completely filled in the

State Registrar

Medical

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANSURIYA 31. Date filed (Month

29c. License number

D 51705

32. Registrar's Signature

			For Stata Registrar	State of Ma	arylan		rtment of		Mental Hy	giene 0 0	4 39209
			1. Decedent's Name (First, Middle,	Last)			ł		2. Date of De	aath	3. Time of Death
	Physici /Medic		_lessica	Nichol	e	Bec			Noven	nber 28 3	004 1100 AM
	Examin	er	4a. Facility Name (If not institution,		.1		4b. City, Town,	or Location of Dea	ath	4c. County of	Shington
	Funeral		Washington Cot 5. Social Security Number	5. Sex 7. Ag		ast birthday)		GEV Stol		th 9	. Birthplace /State or Foreign
п	Director		214-17-3830	1 □ M 2 💢 F	20	Yrs.	Months Days	Hours Mir	_		Country) Pennsylvania
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits
	Maryl F sho	ţō	Maryland Washin	ngton	Н	agerst	own				1 ☐ Yes 🐰 ☐ No
	or 28e	Jirec	10e. Street and Number				10f. Zip Code			10g. Citizen of Wha	
	ath wi	rai	13447 Greencas					740		U.S.A	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23e or 28e-f show any injury or other treumatic event, the Madical Examiner must be rigillised at ance.	by Funeral Director	11. Marital Status  1 XNever Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces?  1  Yes 2 1 If Yes, Give Year or Dates:			Vas Decedent of Yes, specify Cu □ Yes 2 No	Hispanic Origin? (ban, Mexican, Pue	(Specify Yes or No erto Rican, etc.)	14. Race - Black, Specify:	American Indian, White, etc. White
2	72 ho	eted	15. Decedent's (Specify only highest	Education grade completed)		16a. Deced	ent's Usual Occi	pation during most of wed)	orking	16b. Kind of Busin	ness/Industry
121	within ane. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)		oo not use retir :udent	ed)		College	2
о 2	filed Hygir other ent,	e Co	17. Father's Name (First, Middle, L.	ast)		.,,	udenc	18. Mother's N	ame (First, Middle	, Maiden Sumame)	
/lan	should be fi and Mental H s marked ot umatic ever	To Be	Rick L. Becke	r				Angela	a L. Powe	ers Becker	<u>-</u>
Maryland	2 sho		19a. Informant's Name/Relationshi							er, City or Town, Sta	
	ss 1 and 2 of Health a item 27 is		Rick L. Becke	r (Father)	20b. P	lace of Disno	sition (Name of		ike Hager	stown Mai 20c. Location - Cit	ryland 21740
JOL	Pages ent of nt: If it		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		Cec	<sup>emetery, cren</sup> lar Law	natory or other pl m Mem Pa	ark   12;	8/04		wn Maryland
Baltimore,	permit. F Departmo Importer any injur		21. Signature of Funeral Service Li		·						Funeral Home aryland 21742
			23a. Part1. Enter the disease, or c shock, or heart ailure. List o	omplications that caused by one cause on each lin	the death						Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	- Trau	ma	tic	Brai	n In	ury		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequ	vence of):			7 /		
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequ	rence of):					
	cuted nd ransit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events	c							
8760,	cate be executed oblysician and the burial-transit	i Ex	resulting in death) Last	Due to (or as	a consequ	ience of):					
687	physicate t	dicai		d.			_				
Box (	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			[F-4:-			23d. Date of	of delivery
B	e deatl he atte	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at 9☐ Unknown			Ectopic pregnan Other (specify)	cy		Month	Day Year
P.O.	that the de led by the a detached f		9 ☐ Unknown  Part II. Other significant condition		ut not resu	ulting in the ur	nderlying cause o	iven in Part I.	23e. Did 1	tobacco use contribu	ute to the cause of death?
Vital Records,	urres l signe	d by	<b>3</b>				,		_	=	☐ Probably 4 ☐Unknown
COL	law requires as been sign 2 should be	Completed							24a. Was		re autopsy findings available
Ä	The ate h page	mo							auto perfo	rmed? dea	or to completion of cause of ath? ] Yes 2 2 No
/ita	Physician: r this certificaral director,	Ee	25. Was case referred to medical examiner?	Hospital:			10	ala	eath (Check only		
of	Phys r this ral dir	. To	1 Yes 2 No 27. Manner of Death	28a. Date of Inju		ER/Outpatien 28b. Time of	28c. Inj			dence 6 Other	(Specify) Struck quanter
Division	Attending Fir death. ector: After by the funer	Certification:	1 □Natural 5 □ Pending 2 ☑ Accident investiga	(Month, Day	OU	Iniury	W	ork? ]Yes 2. <b>∏</b> No	Ritica	telete	1 from behicle
ivis	I or Attendi after death. Director: A I in by the fu	tiffc	3 Suicide 6 Could no 4 Homicide determin		/rv - At ho	me, farm, stre	et, factory, office		28f. Location ( City or To		or Rural Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer		00 0 miles	Gr	eer	ncast	-le P	ke	Hag	erstown	
	To the Hospitel within 24 hours a To the Funerel I completely filled	edicai	29a. Certifier 1 ☐ Certifying (Check only one)  Certifying  2 ☐ Medical E	Physician: To the best of kaminer: On the basis of Aand manner sta	examinat	ion and/or inv	estigation, in my	opinion, death oc	curred at the time,	date and place, and	er as stated. I due to the cause(s)
	To the within To the Compl	Me	29b. Signature and title of prified			_		ise number		29d. Date signed (A	Wonth, Day, Year)
}			) // (r	bert	, DO	FACE	P	140881	1	11 2	2004
4	1-3		7/	ho completed cause of d	eath (Item	23a) (Type,	Print) 25	EANTIE	tam st	Vincai Lul IL	21740
١	Sta	te	31. Date filed (Month, Day, Year)	32. *egistra	s Signal	THE	WA	o Hington	LOWNTY 1	BUSY TOU IT	28 2004 Serstown, MD
37	Registr		DEC 0 1	2004 Janes	an d	J. Sp	refer				

RICHARD CARL BOWEN

State of Maryland / Department of Health and Mental Hygiege 0 For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) NOVEMBER 17, 2004 **Physician** 8:30 P M BERKMAN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner MONTGOMERY BETHESDA SUBURBAN HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year APRIL 20, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number ). 1928 MICHIGAN **Funeral** 1 □ M 2 □ F Yrs. Director 579-30-0897 76 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28s-f show the Medical Examiner must be notified at 1√Yes 2□No Directo ROCKVILLE MARYLAND MONTGOMERY 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 9 UNITED STATES Itams 23a 12030 CHASE CROSSING, #102 20852 death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or item any injury or other trsumatic event, the Widtoll Examination. 1 ☐ Yes 2X No if Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed by WHITE 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) FEDERAL GOVERNMENT SECRETARY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **EPSTEIN** BERKMAN RAE 2 SAMUEL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12030 CHASE CROSSING, #102 ROCKVILLE, MD BETTY E. BERKMAN, SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 X Reproval from State COMFORT CREMATORY 11/22/2004 ALEXANDRIA, VA \* 4 ☐ Ponation 5 ☐ Other (Specify) 21. Signature of Funeral Sarrice No-nsee 22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 02 20852 1170 ROCKVILLE PIKE, ROCKVILLE, MD 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final DAYS Pnysician ANOXIC BRAIN DAMAGE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 4 DAYS ASPIRATION PNEUMONIA Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Examine The law requires that the death certificate be axecuted use as the burial-transit UNKNOWN CHRONIC OBSTRUCTIVE PULMONARY DISEASE the attending physician and hed for use as the burial-tra resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4□Pregnant at time of death 9 Unknown 9 Unknown Aftar this certificate has been signed by funeral director, page 2 should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 2 🔀 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 X Natural 5 Pending 1 🗌 Yes 2 No within 24 hours after death.

To the Funers! Diractor: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier 2 November 23,2004 D56652 2 MA 30. Name and addres of person who completed cause of death (item 23a) (Type, Print) MATTHEW G. POFFENROTH, M.D., 809 VIERS MILL ROAD, #101 ROCKVILLE, MD 31. Date filed (Month, Day, Year) 32. Begistrar's Signature NOV 24 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg.No. 1 - For State Registrar Jaby Bennett, Girl, Elizabeth 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 9:50 DM Kayla Marie Bennett November 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Shady Grove Adventist Hospital If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 8. Date of Birth (Month, Day, Year) 1 ☐ M 2 🔂 F October 30, Director 20 2004 Maryland 215-71-0748 the Marylend 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at Walkersville Maryland 1 ☐ Yes 2 🕱 No Frederick Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21793 115 Polaris Drive Funerai 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 21 No If Yes, Give Year or Dates: 1 Never Married 2 Married white 1 Yes 2000 Specify: Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

| Compared to the compared to the 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) n/a n/a 18. Mother's Name (First, Middle, Meiden Surname) 17. Father's Name (First, Middle, Last) Be Mental Elizabeth Turner Robert Bennett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
115 Polaris Drive, Walkersville, Maryland 21793 pue 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 end 2 sh Depertment of Heelth end Important: if item 27 ie m eny injury or other traum ance. Robert Bennett - Father Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Frederick Crematory NOV. 24, 2004 Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service License 1621 Opossumtown Pike, Frederick, Maryland 21793 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final hyperkalemia **Physician** hrs disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner acute rena Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed ettending physiclen end for use es the burlel-trensit 051 Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical motur IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) this certificete has been signed by the real director, page 2 should be deteched 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 1 Yes 25 No To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p : After this certification at the funeral director, it Be 25. Was case referred to medicaf 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA 2 1 ☐ Yes 2 ☑ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M. D 11.19.04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDINA 990 VESTEL OVSZKY

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32. Registraris Signature

9

2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 21, Month **Physician** 2004 8:09 p November Bogley Susan Hogeland /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Tracy's Landing Anne Arundel 329 Highview Road If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F May 14, 1948 Director 169-40-1980 56 Pennsylvania Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Show item 27 is marked other then "natural", or items 23a or 28a-f show other treumatic event, the Medical Examinar must be inclined at 1 ☐ Yes 2 XNo Tracy's Landing Director Anne Arundel MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? death with U.S.A. 329 Highview Road 20779 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural; or item any injury or other treumatic event, the Medical Exemples 2008. Black, White, etc. 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) landscaping office director 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hogeland Katherin Kratz ပ James Pearson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 329 Highview Rd., Tracy's Landing, MD 20779 John Aubrey Bogley, husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 11/23/2004 Alexandria, VA 21. Signature of Funeral Service 22. Name and Address of Facility Rausch Funeral Home, P.A., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final tancientie Cancer Priysician Tmonths disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) ed by the 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş should be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed2 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 4 Nursing Home 5 Residence 6 □Other (Specify) the funeral dir 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Peath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After To the Hospitel or Attending Matural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deatl Funeral Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide filled in Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Messics/MP, 180 Admi 32. Registras Signature State 2004 Registra

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H	Physicia	an	Registrer  1. Decedent's Name (First, Middle, Las	t)		FILITICAL	e oi Dea	<i>ur</i>	2. Date of De	Reg. No.		3. Time of Death
	/Medic	al	Olive G. Bridges  4a. Facility Name (If not institution, give	street and number)		4b City	Town, or Locati	ion of Death		740	County of Death	11:35 A.M.
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	Funeral Director		5. Social Security Number 6. St 218 12 5438	9x 7. Age (In yr	s. last birthda Yrs.	y) If Under Months	1 Year If Un Days Hou	der 24 Hrs. rs Min.	8. Date of Bir (Month, Da 11-13	th ay, Year) ~192	9. Birth Cou 4 MD	place (State or Foreign intry)
	ow II		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or	Location						10d. Inside City Limits
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0-00-0	filed within 72 hours after death with the Maryland I Hygiene then "naturel", or Items 23a or 28a-f show other then "naturel", or Items 73a or 28a-f show ent, the Medical Examina must be notified at	by	1 Never Married 2 Married  Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		If Yes, sped			Rican, etc.)		Black, White	, etc. Uhite
2-0	72 ho natur	Completed	15. Decedent's Ed (Specify only highest gra	ucation de <i>completed)</i>	16a. Dec (Giv	edent's Usua ve kind of wo	al Occupation rk done during r se retired)	most of work	ing	16b. Ki	nd of Business/I	ndustry
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Mar	permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other eny injury or other treumetic event, 100ce.		19a. Informant's Name/Relationship (1) Teresa A. Emerick			_	i (Street and Nu Iman Roa				r Town, State, Zi 15545	ip Code)
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Баппо	permit. Departi Importi eny inj once.		21. Signature of Eureral Service Licen	500			nd Address of Fa		Europal	Ll auss	e, Hyndn	agua DA
	402 9 Q		23a. Part1 Enter the disease or com	olications that caused the de							e, ngnan	Approximate
	Physician		shock, or near failure. List only Immediate Cause (Final disease or condition		om &	or P		· U	'me	tact	tagie	Interval Between Onset and Death MM Hh
	/Medical Examiner		resulting in death)	a. Carain  Due to (or as a cons	equence of):	1	mg vi	V(1)		1 003 3	4-5	provinces
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ο X	leath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pred						2	23d. Date of deliv	very
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n of	ng Phys (fter this ineral di	on: T	27. Manner of Death	28a. Date of Injury (Month, Day Year,	28b. Time Injury		28c. Injury at Work?		28d. Describe	how injur	y occurred	
DIVISION	ttendi death. stor: A / the fu	ertification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		t home, farm,	M street factor	1 ☐ Yes 2		28f. Location	Street an	d Number or Ru	rai Route Number,
2	itel or A rs after al Dire led in by	Certii	4 Homicide determined	building, etc. (Spe	ocify)				City or To	wn, State	)	
	To the Hospitel or Attending Physician: within 24 hours after death To the Funeral Director: After this certifica completely filled in by the funeral director,	edical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exert one)	ysician: To the best of my lands and manner stated.	nowledge, de ination and/or	ath occurred investigation	at the time, date i, in my opinion,	e and place, death occur	and due to the red at the time,	cause(s) date and	and manner as I place, and due	stated. to the cause(s)
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	nes		Or. Tesus Tan	completed cause of death (I	-	e, Print)	Frostbi	urg h	laryla	nd	21532	
Ü	Sta		31. Date filed (Month, Day, Year) NOV 2 200	32/Registrar's Sig	<u> </u>	Loc	Wh	-				

		1 - For State Registrar	State of M		/ Depa		f Health	and M			) O L	39216
		Decedent's Name (First, Middle, L.)	ast)						2. Date of Death	1		3. Time of Death
Physicia		Harold	G	ene	Е	Bonner		1	NOVEMBER	2 <sup>a</sup> y,	2004	1500 p. M
/Medic Examin		4a. Facility Name (If not institution, g	ive street and number)			4b. City, Town	n, or Location	of Death		4c. Cou	unty of Death	1
	3	Memorial Hosp	ital			CUMBER	LAND			ALLE	GANY	
Funeral			15 N 205	ge (In yrs. las	- 1	If Under 1 Ye Months Da		24 Hrs. Min,	8. Date of Birth (Month, Day, 03/15/1	Year)	9. Birth	place (State or Foreign ntry) t Virginia
Director		213-24-5694	10 W 20 F	77	Yrs.				03/15/1	927	Wes	t Virginia
land W		Usual Residence of Decedent  10a. State 10b. County	-	10c. City, 7	Town or Lo	cation					1	IOd. Inside City Limits
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ems ems	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. \	Was Decedent of Yes, specify C	of Hispanic Or Cuban, Mexica	igin? (Spen, Puerto	cify Yes or No- Rican, etc.)		Race - Americ Black, White,	
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Ind ZIZI be filed within tal Hygiene. d other then ' event, the we	BeC	17. Father's Name (First, Middle, La					18. Moth	er's Name	(First, Middle, M	laiden Sur	пате)	
Viand vuld be file Mental Hy arked oth stic event	To E	James	Во	nner			Ma	bel			White	
Baltimore, Maryland ZIZIS-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "neturel", or Items 23e or 28e-1 ehow enty injury or other treumatic event, the Medical Examinar must be notified at ance.		19a. Informant's Name/Relationship Betty L. Swang		4	19b. Mailin	ng Address (Str Box 63	eet and Numb	er or Rura	I Route Number, V. WV 2	City or To	wn, State, Zip	Code)
C, N 1 and 1 ealth 1 ealth 1 m 27 1 her tu				20h Plac							on - City or To	own State
Saltimore, bernit. Pages 1 a Department of Her mportent: if item any injury or othe		20a. Method of Disposition 1X Burial 2 □ Cremation 3				sition (Name of natory or other) st Mem.					•	
it. Pa rtmer rtent rtent njury		<ul> <li>4 □ Donation 5 □ Other (Special Signature of Juneral Service Lie</li> </ul>		nii					72004 ams Fami		berland	
balt permit. Departi Import eny inj		1 1 1 1	21 1		-				t, Cumbe	•		21502
		23a Part1. Enter the disease, or co	mplications that cause	d the death.	Do not ent	er the mode of	dying, such as	cardiac c	r respiratory arre	st,		Approximate Interval Between
Pnysician		shock, or heart failure. List on Immediate Cause (Final			L	1	)		n. Die	0064		Onset and Death
/Medical		disease or condition resulting in death)		a conseque		TIVE F	uine	mar	y Dis	easi		oyears
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p =	iner	Sequentially list conditions, in any, isaging to infine trade cause. Enter Underlying Cause (Disease or injury	Due to (or as	8:00086009	nee of):							
ecute and -trans	Examin	that initiated events resulting in death) Last	c Due to (or as	2 0050001101	nce of):							
COIdS, P.O. BOX b8/bu, wrequires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	cal E		500 10 (01 83	a conseque	1100 01).							
box box box defineste attending phys d for use as the			d									
Certification of the second of	J/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d.	Date of delive	ery
death ce	iciai	in the past 12 months?	1□Live birth 4□Pregnant a			Ectopic pregna Other (specify					Month	Day Year
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Ords, F.C. requires that the een signed by th hould be detache	by P	Part II. Other significant conditions	contributing to death t	out not resulti	ing in the ur	nderlying cause	given in Part	l.				ne cause of death?
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lawr las be	ompleted								24a. Was an autopsy	, I	prior to co	psy findings available mpletion of cause of
The law	S								perform 1 Yes 2,	ed? ZNo	death? 1 🗌 Yes	2 🗷 No
Or VIÇAL P Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:						(Check only one			
or hys	- To	1 Yes 2 No	1 Izinpati		NOutpatien 8b. Time of	t 3 DOA	nuny at		me 5 Resider 28d. Describe hov			y)
ding h. After	tion	1 ZNatural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	Injury		njuryat Work? I∐Yes 2⊡		Edd. Describe No.	w injury oc	curred	
ISI Isten dear ctor y the	ertification:	3 ☐ Suicide 6 ☐ Could not	t be 28e. Place of In	jury - At hom	e, farm, str				28f. Location (Str	eet and No	ımber or Rura	ul Route Number,
i Pite	erti	4  Homicide determine	building, e	tc. (Specify)					City or Town,	State)		
e Hospitel 24 hours a Funerel l	calC	29a. Certifier (Check only 2 Medical Ex	Physician: To the best	of my knowle	edge, death	occurred at the	e time, date ar	nd place,	and due to the car	use(s) and	I manner as s	tated.
	ledical	one)	and manner st	tated.	aricy of in			an occurr				
To the within 2 To the complet	Σ	29b. Signature and title of certifier	f. Chotan				ense number	2			gned (Month,	Day, Year)
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SIRS		30. Name and address of person wh DR. HABIB CHOTANI					יא זמים מוש"	ND M	DVI ANTS (	)1500		
Sta	ite	31. Date filed (Month, Day, Year)		rar's Signatur	re,			IVI) IYLE	KILAND A	21302		
Registi		NOV 2 9 2004	4 Jenne	a /	ly de	porks	/					

					State of Maryla	nd / Department	of Health and M	-	10	
				1 - For State Registrar	orano or many ta	Certificate		Reg. N	14 09	217
		Physic /Medi Examir	cal	Decedent's Name (First, Middle, Last)     Aa. Facility Name (If not institution, give s	HNN	Brown 4b. City, To	own, or Location of Death	2. Date of Death Month Da	ay Year	3. Time of Death 02:35 9. M
	7	Funeral Director		5. Social Security Number 6. Sex	7. Age (In rs	s. last birthday) If Under 1 Months C	Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year	9. Birth Cou	place (State or Foreign intry)
		within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Moulcal Exeminer must be notified at	Director	10a. State 10b. County	10c. 0	Conoko	City			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
		vurs after death with the Maryla al; or items 23a or 28a-f sho Examiner must be notified at	Funeral Dir	800 Lynhau	12. Was Decedent Ever in Armed Forces?	U.S. 13. Was Deceder	ode    J		14. Race - Ameri Black, White	ican Indian,
5	5-0036	72 hours afte natural; or it	by	1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Educ	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 Yes 2	No Specify:	160	Specify: B	ack
02	2121	77 75 75	<b>Completed</b>	(Specify only highest grade Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)	College (1-4or 5+)	Give kind of work of life. DO NOT use		(First, Middle, Maide)	) (1-1)	Mart
pol	Maryland	2 should be filed and Mental Hygi Is marked other aumatic event.	To Be	Edward Ruc  19a. Informant's Name/Relationship (T	mond	Brown	Jean	Hua	her	
holhell		1 and 1 1ealth 8m 27 ther tr		Jean Brown 20a Mothed of Disposition	I (mothe	Place of Disposition (Name	Street and Number or Rura	condo	or Town, State, Zij	2/85,
_	Baltimore,	nit. Page artment c ortant: If injury or		1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify) 21. Separation 2 Tuneral Service License	- Cr	cemetery, crematory or othe	John 11-2	7-04 De	lmar 1	nd, eral Hom.
	B	Dep Imp		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the dea	P.O. Bo	20331 POCI	moke ( r respiratory arrest,	ity, m	d.21851
375		Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse	immunod	ficiency	discrale	nsyndi	Interval Between Onset and Death
36.36			Examiner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):		<u>-</u> -		
107-6	3760,	ate be executed hysician and the burial-transit	cat	that initiated events 'resulting in death) Last	Due to (or as a conse	quence of):		<i>(1741-12)</i>		
rown Country	O. Box 68	it the death certifical by the attending phy tached for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3 Ectopic pregr			23d. Date of deliver	ery Day Year
15	rds, P	quires that the signed by and be detacted	by	Part II. Other significant conditions con	tributing to death but not re	sulting in the underlying caus	se given in Part I.	23e. Did tobacco		he cause of death?
Orie	al Record	: The law requires that the cate has been signed by the page 2 should be detache	Completed					24a. Was an autopsy performed?	prior to co death?	psy findings available mpletion of cause of 2 No
	Vital	Physician: Th this certificate ral director, pag	Be c	25. Was case referred to medical examiner?  1 Yes 2 No	ospital:		26. Place of Death Other:			
Ma	ion of	ling After fune	ıtlon: To	1 Yes 2 No 127  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 X npatient 2 28a. Date of Injury (Month, Day Year)	Injury	4   Nutsing Hor	ne 5 Residence 8d. Describe how injur		y)
	Division	Hospital or Attendi 24 hours after death. Funeral Director: A tely filled in by the fu	Certification;	3 Suicide 6 Could not be determined	building, etc. (Speci			8f. Location (Street ar City or Town, State	e)	
		To the Hospital or I within 24 hours after To the Funeral Directonpletely filled in b	edical	29a. Certifier 1 Certifying Phys. (Check only one)	ician: To the best of my kn er: On the basis of examin- and manner stated.	owledge, death occurred at the atom and/or investigation, in	he time, date and place, a my opinion, death occurre	nd due to the cause(s) d at the time, date and	and manner as si d place, and due to	lated. the cause(s)
		To the within 2 To the complet	Me	29b. Signature and little of certifier	0 /		icense number		te signed (Month,	
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5	T	- 2		30. Name and address of person who of the street of the st	32. Registrar's Sign	m 23a) (Type, Print) ) 33 Healt	060535 hway Dr	ive, Ber	-lin r	ld.
	35	Sta Registr		NOV 2 9 2		H. Coasts	,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#18, perFH\_G839\_1/5/05 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** December 06.2004 HAZEL BOBLITZ 1:56 a M MARIE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Skipjack Place Pasadena Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. | June 13, 1931 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Months 1 ☐ M 2 🕅 F 199-24-8913 73 Yrs Pennsylvania Director Usual Residence of Decedent the Maryland 10c City Town or Location 10a State 10b County 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Anne Arundel Pasadena 1 ☐ Yes 2X No Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 and 2 should be filed within 72 hours after death with Health and Mental Hygiene. em 27 ie marked other than "natural", or Items 23a or 8554 Skipjack Place 21122 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Marfied 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ Specify: 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Waitress Food 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George R. Hodge Flora H. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Roxanne Lins, Daughter 8554 Skipjack Place, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Dec. 10, 1 Burial 2 Cremation 3 Kemoval from State 4 ☐ Donation 5 ☐ Other (Specify) New Freedom Cemetery New Freedom, PA 21. Sign W re of uner Service J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, earl failure. List only one cause on each line. Approximate Interval Between Onset and Death "Ent Immediate Cause (Final disea e or condition resulting in death) 10 Physician whom /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of a uence of). Examiner be executed Due to (or as a consequence of): burial-Box 68760 Physician/Medical The law requires that the death certificate the attending p for use as as IF FFMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐ Pregnant at time of death 5 Other (specify) P.O. the a detached 9 Unknown signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 21000 1 TYes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an has 2 No certificate 1 Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check onl on 1 Yes 2 No Hospital: Other: 2 5 Sesidence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 4 Nursing Home 3 DOA this 28c. Injury at Work? 27. Manner of Deat 28a. Date of Injury (Month, Day Year, 28b. Time of 28d. escribe how injury occurred Certification: After Natural 5 Pending death. Accident investigation in by the Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a To the Funerel C 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) SAC 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day Month **Physician** MARY GLADYS BESSEY 2004 /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1325 W. Jarrettsville Road Forest Hill Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 8/28/1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 F 91 Director 217-22-0657 Maryland Usuel Residence of Decedent the Maryland 10a State 10b Counts 10c. City, Town or Location 10d. Inside City Limits "neturel", or items 23e or 28e-f shov digal Examinar must be notified at 1 ☐ Yes 2 No by Funeral Director MD. Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with it. Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23e or 2; any injury or other treumatic event, the Markel Example must he page. 1325 W. Jarrettsville Road 21050 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 Widowed 4 □ Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 0 Housewife Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Phillips George Barclay 2 Zora 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce K. Bessey/Daughter 2010 Brandy Drive Forest Hill, Md. 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 13/9 1 Burial 2 Cremation 3 Removal from State '4 □ Donation 5 □ Other (Specify)

21. Signature of Funer 1 → Yice Leen ee William Watters Cem. 2004 Cooptown, Maryland 22. Name and Address of Facility Jarrettsville, Maryland E.G. Kurtz & Son Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) oca /Medical Due to (or s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease of 1) that initiated events Examiner The law requires that the death certificate be executed nding physician and use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 1 Yes Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. within 24 hours after death.

To the Funerel Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 Jeman ompleted cause of death (Item 23a) (Type, Print) 30. Name and address of person 32. Registrar's Signatur Date filed (Month, Day, Year DEC 1 0 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 911 NOVEMBER 20 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HEBREW HOME OF GREATER WASHINGTON ROCKVILLE MONTGOMERY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, JAN 8, 9. Birthplace (State or Foreign **Funeral** 1√ M 2 F Days Hours WASHINGTON, DC Director 92 YES 578-10-3902 Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "naturel", or Items 23s or 28s-f show other treumetic event. It s Medical Examiner must be notified at Director Yes 2 No MARYLAND MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6111 MONTROSE ROAD 20852 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XXYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene Important: If item 27 is marked other then "naturel", or Item any highry or other treumetic event, the Modical Examirer once. Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify 3 ☑ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DENTIST 5+ DENTISTRY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MEYER COHEN BESSIE WOLF. ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ROBERT E. COHEN, SON 11503 FEBRUARY CIRCLE, #304 SILVER SPRING, MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 Donation 5 Dother (Specify) MD VETERANS CEMETERY 11-30-2004 CHELTENHAM, MARYLAND 21. Signature of Funeral Service Licensee EDWARD SAGEL FUNERAL DIRECTION, INC. Oonald. 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CONGESTIVE HEADT **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physicien for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) P.O. I the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 4. Unknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 2 No 1 Yes 1 Yes 2 X No the Hospitel or Attending Physician: director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA his 28a. Date of Injury (Month, Day Year) After thi 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No investigation hours after death. Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 10 30. Name and address of person, who completed cause of death (item 23a) (Type, Print DDAD, ROCKVILLE, MD 2085 31. Date filed (Month, Day, Year) 32. Registrar's Signature **NOV 24** 2004 Registrar

			For State Registrar	State of Man		artment of F			giene	30221
	Physic's		Decedent's Name (First, Middle, Last)				·····	2. Date of Dea Month	ith	3. Time of Death
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	Examin	er	4a. Facility Name (If not institution, give s		-		r Location of Deat	h	4c. County of I	
*	- *		Frederick Memori  5. Social Security Number 6. Sex		h yrs. last birthday	Freder		8. Date of Birth	Frede	Birthplace (State or Foreign
ľ	Funeral Director			M 2□F 78		Months Days	Hours Min.	Oct. 28	/, Year)	Country)
	pu ,		Usual Residence of Decedent  10a. State 10b. County	14	Oc. City, Town or L	anation.				
	faryla shov	ō								10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	hours after death with the Maryland tural', or Itams 23a or 28a-f ahow Exerticer mast be notified at	Director	Maryland Frederic  10e. Street and Number	k	Freder	1.C K 10f. Zip Code			10g. Citizen of Wha	it Country?
	3a or		126 W. Chruch Str	eet		217	n1		United S	,
	deatl	Funeral		12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of H	lispanic Origin? (S	pecify Yes or No-	14. Race -	American Indian, White, etc.
36	or Ita		1 Never Married 2 X Married	1 X Yes 2 ☐ No If Yes, Give		1 ☐ Yes 2 ☒ No	Specify:	.o r (1041), 0(0.)	Specify:	White
Ö	n 72 hours after death with the Marylan "natural", or Itams 23a or 28a-f ahow ofce Err riter mat be notified at	ed by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates: V	WII	dent's Usual Occup	ation		16b. Kind of Busin	
15	d within 72 ho piene. r than "natur Ine Medical	plet	(Specify only highest grade	completed)	(Give	kind of work done  DO NOT use retired	during most of wor	rking	TOD. KING OF BUSIN	essindustry
212	d within glene. ar than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 5+	Ec	onomist			Non-Prof	it Organizatio
nd	e filed all Hygie	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle,	Maiden Sumame)	
yla	2 should be f and Mental h is markad of raumatic ava	To	Earl Theodore Cr					Janelli		
Maryland 21215-0036	nd 2 sh lith and 27 is n r traum		19a. Informant's Name/Relationship (Type Carrie W. Crosson			ng Address (Street				
	s 1 and 2 should be filed f Health and Mental Hyg itam 27 is merked othe other traumetic avent,		20a. Method of Disposition		20b. Place of Disp	osition (Name of		Date	20c. Location - City	and 21701 y or Town, State
E C	Pages ent of nt: If i		1 ☐ Burial 2 ☑ Cremation 3 ☐ Re  4 ☐ Donation 5 ☐ Other (Specify)		_	matory or other place k Cremato:	NOVE	ember 2004 ]	Frederick	, Maryland
Baltimore,	permit. Pages 1 an Department of Heal Important: If itam 2 any injury or other once.		21. Signature of Funeral Service License		2	2. Name and Addre	ss of Facility St.	auffer F	uneral Ho	mes, P.A.
<u>m</u>	8858			and the second s	10	621 Oposs	umtown P	ike Fred	derick, M	aryland 21702
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	e cause on each line.	e death. Do not en	1	_	or respiratory are	rest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Acute	Right 1	er Isel	remia'			4 Deex
	/Medical Examiner			Due to (or as a c	,	0				Strange
k		ler	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a c						8
	cuted	Examiner	Cause (Disease or injury that initiated events							
, 0,	cate be executed oblysician and the burial-transit		resulting in death) Last	Due to (or as a c	onsequence of):					
8760,	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Medlcal	d					-		
9	death certifica attending ph d for use as th	/Me	IF FEMALE:	3c. If yes, outcome of p	pregnancy				23d. Date of	f dolivon
Вох	death atten	ician	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 [ 4 Pregnant at tim	Fetal death 3	□Ectopic pregnancy □ Other (specify)	1		Month	Day Year
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S, P	se us	by P	Part II. Other significant conditions con	tributing to death but r	not resulting in the u	ınderlying cause giv	en in Part I.			te to the cause of death?
ord	w requir been si should I	ted	Stroke					1 U Y	es 2 No 3	Probably 4 Unknown
Vital Record	aw is b	ompleted						24a. Was a autop: perfor	sy prior	e autopsy findings available r to completion of cause of
<u>a</u>	Thate at a	O	OS Was and the medical					1 Yes	2 <b>X</b> No 1□	Yes 2□ No
Ξ		To Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital: 1 Anpatient	2 ☐ ER/Outpatie	nt 3 DOA Oth	or	ath (Check only or	ne) ence 6 □Other(	Speciful
J Of	ig Physical this neral di		27. Manner of Death	28a. Date of Injury (Month, Day Y	28b. Time o				ow injury occurred	
Sio	Attanding Fer death. ractor: After by the funer	atlc	2 Accident investigation		, , , , ,		Yes 2 □ No			
Division	l or Att after d Diract in by	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (	<ul> <li>At home, farm, st Specify)</li> </ul>	reet, factory, office		28f. Location (S City or Tow		r Rural Route Number,
	Hospital or 24 hours afte Funaral Dir stely filled in		29a. Certifier 1 Certifying Phys	ician: To the best of n	ny knowledge deal	h occurred at the tir	ne date and place	and due to the c	ause(s) and manne	ar as stated
	To tha Hospital or Attanding Phwithin 24 hours after death. To tha Funaral Diractor: After th completely filled in by the funeral	edical		er: On the basis of ex	amination and/or in	ivestigation, in my o	pinion, death occu	rred at the time, o	late and place, and	due to the cause(s)
	To tha within 2 To tha complet	Me	29b. Signature and title of certifier			29c. Licens	e number	2	29d. Date signed (N	fonth, Day, Year)
)			<b>)</b>	2		Dy	3091		11-26-69	,
f	1		30. Name and address of person who co	Parich	h (Item 23a) (Type,	Print) SO1	Tore to	tause A	29d. Date signed (N 11-26-67 K, Frz	deale
I &	Sta Registr	- 5	31. Date filed (Month, Day, Year) NOV 2 9	32. Registrar's	Signature	5 1	and 1		,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [ ] Amend Item # 14 39222 1- state Amend Item 17.818 per of h 6839 we drift cate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Pong Un Chong November 24,2004 1:30p /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Union Hospital 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 200 F Yrs. 60 Director 221-60-0966 10,1944 South Korea Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show traumatic evant, the Medical Examiner must be notified at 1 ☐ Yes 2X No **Funeral Director** MD Cecil Elkton 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 238 1551 Augustine Herman Hwy. 21921 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □ Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Asian Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 ☐ No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) Chong's Produce 9 Owner/Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should ba fil ment of Health and Mantal H tant: If Itam 27 is marked otl Unknown Song Chan Ahn Geh Soon Oh -Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1551 Augustine Herman Hwy., Elkton, MD 21921 e of Disposition (Name of Date Date 20c. Location City or Town, State Chan Hwa Chong/Husband othar 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any injury or one `4 ☐ Donation 5 ☐ Other (Specify) Gilpin Manor Nov. 27,2004 Elkton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Andrew G. Gee Funeral Home Keelin 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21921 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Collapse **Physician** Cardiovasavar dayi /Medical Examiner under Ino Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed burial-transit 7 STEWICE attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical for use as tha IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 glonths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month 5 Other (specify) P.0. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by ed bluods 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 🕱 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No page 2 or Attanding Physician: After this certification, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 25 Certification: To 1 Yes Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 \ Homicide Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) tha 29b. Signature and title of centifier 29d. Date signed (Month, Day, Year) November 29 in 30. Name and addre s of person who completed cause of death (Item 23a) (Type, Print) Bow St Elleten MD MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 29 Registrar

			1 - For State Registrar	State of Marylar		artment ortificate				00	04	39223	
7	Physici /Medic Examir	cal	Decedent's Name (First, Middle, Last     Gabriel Johnath      4a. Fecility Name (If not institution, give	an Cates		4b. City, To	wn, or L	ocation of Deat	2. Date of Dea Month NOV.	Day	Year 004 of Deeth	3. Time of Death	
	Funeral Director		Anne Arundel Medi  5. Social Security Number 6. Se  N/A  Usual Residence of Decedent		last birthday) Yrs.	If Under 1	Year	polis If Under 24 Hrs Hours Min. 6	8. Date of Birth (Month, Day NOV • 2			rundel lace (Stete or Foreign try) MD	
	death with the Maryland ms 23a or 28a-f ehow	ector	10a. State 10b. County	Arundel 10c. Ci	ty, Town or Lo			Burnie		Co. Citizen Alla		0d. Inside City Limits 1 ☐ Yes 2 ☑ No	
	r death with ams 23e or er must be r	Funeral Director	355 Monticello Co	Ourt  12. Was Decedent Ever in U	J.S. 13. \			21061 Danic Origin? (S	pecify Yes or No-	14. Race	USA  - America k, White, 6	an Indian,	
21215-0036	within 72 hours after ene. then "neturel", or Ita	by	1 XNever Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Edu	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	16a. Deced	1 ☐ Yes 2 🔀	No Occupation	Specify:		Specify:	W	hite	
	filed within 7 Hygiene. other than "n	e Completed	(Specify only highest grad  Elementary/Secondary (0-12)  N/A  17. Father's Name (First, Middle, Last)	College (1-4or 5+)	life.	N/A	retired)	nost of work	ne (First, Middle, i		N/A		
Maryland	2 should be and Mental le markad c	To Be	Elijah Cates 19a. Informant's Name/Relationship (T)				îtreet and	Jessica d Number or Ru	a Lotz Iral Route Number	, City or Town, S	State, Zip	Code)	
altimore, I	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial hygiene. Important: If item 27 is marked other than "natural; or itams 23s or 28s-f show may injury or other traumatic evant, the Macical Examination must be notified at once.		Elijah Cates/Fathe  20a. Method of Disposition  1X Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)	20b. I Removal from State	Place of Dispo cemetery, cren	sition (Name natory or othe	of ir place)	Nov	7. 24,	20c. Location - 0	City or Tov		
Balti	permit. Page Department of Important: If any injury or		Glen Haven Mem. Pk. 2004 Glen burnie, In 2004 Glen										
	Physician /Medical		Sale Park. Enter the disease, or complishing, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	a. Multiple to (or as a consection)	Do not ent	er the mode o	of dying,	such as cardiac	in respiratory arresponding to the second	est,		Approximate Interval Between Onset and Death	
8760,	rate be executed hysician and the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):										6 hrs	
O. Box 6	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes ☑ No 9 □ Unknown	23c. If yes, outcome of pregns 1 Live birth 2 Feta 4 Pregnant at time of c	ldeath 3□	Ectopic pregr Other (specia				23d. Date Mon	of deliver	Y Day Year	
ords, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions con	ntributing to death but not res	ulting in the ur	nderlying caus	se given	in Part I.	23e. Did tob	_		e cause of death?	
Vital Record	The ate h page	e Completed	25. Was case referred to medical					C. Please of Day		pr 1ed? de 150 No 1 (	ere autop for to com ath? Yes 2	sy findings available pletion of cause of	
Division of Vi	ding Ph h. After th funeral	ation: To B	examiner?	Hospital: 1 Inpatient 2  28a. Date of Injury (Month, Day Yeer)	ER/Outpatient 28b. Time of Injury	ime of 28c. Injury at 28d. Describe how injury occurred							
Divis		i Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	y) 				28f. Location (Sti City or Town	, State)			
	To the Hospital or within 24 hours after to the Funeral Discompletely filled in	Medical	29a. Certifier (Check only one) Certifying Physical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	tion and/or inv	estigation, in	he time, my opini cense n	ion, death occu	rred at the time, da	use(s) and man ite and place, ar d. Date signed	nd due to t	the cause(s)	
)			30. Name and address of person who co	ompleted cause of death (Item	OO n 23a) (Type, I	,	49	1733	) i	Jovemb	er 6	0 21401	
	Sta Registr		31. Date filed (Month, Day, Year)  NOV 2.3. 20	GRISCH 00 32 Jegistrar's Signa	200 l	Me	gree	al Pk	ng Ar	nespoli	5 M	0 21401	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) Day **Physician** Year **Thomas William Carter** 02:30 A November 25, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Devlin Manor Nursing Home Cumberland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 10**X**M 2□F Months Hours Yrs. Director 213-40-3564 63 Maryland 20-Oct-1941 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28e-f show s 23a or 28e-f show 1) Yes 2 □ No Director Maryland Allegany Frostbura 10e. Street and Number 216 Show Street 10f. Zip Code 10g. Citizen of What Country? 21532-U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) "neture!', or items 11. Marital Status 14. Race - American Indian, The Madigal Examiner r Black, White, etc. 1 ☐ Yes 2' No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No Specify: δ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) reading specialist education permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any jury or other treumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Nicholas Carter Sarah Ellen Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Victoria Lane niece Lisa Harris Frostburg Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 29-Nov-2004 Mount Savage Maryland Saint Patrick's Cemeterv \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Acensee 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset, and Death Immediate Cause (Final disease or condition resulting in death) CIRRHOSIS **Physician** LIVER neuro /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner resulting in death) Last Due to (or as a consequence of): by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 1 Yes 2 No 2 No 1 Yes To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ۴ this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \( \text{Homicide} \) within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier ML 1070/ New Heave Preels S.W. Front burne Maryland 21532 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) n RD CHANGIN.D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 39225 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Dec 4, 2004 10:10 am Cooper Catherine Anna /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Cumberland New Hope Assisted Living Center If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Aug 12, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 F 1912 217-54-6215 92 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits MD Allegany Cumberland Completed by Funeral Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 11609 Bierman Drive 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Specify: white 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Ownhome 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **Edward Liller** Edna Eshbaugh Liller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WV 26719 P.O. Box 171 Robert Cooper Fort Ashby son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State Mt. Tabor Cemetery 12/7/2004 MD Spring Gap 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Scarpelli Funeral Home, P.A. 108 Virginia Avenue; Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or learn failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or candition resulting in death) e +50 Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events Examiner Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 3 No 2 No 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification; To 2 **N**o 1 🖸 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide 1 Lestrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D54411 12-4-04 32. Registrar's Signature 4 Ave Ste 105 Cumberland MD 21502 30. Na so indiaddress of our on who completed cause of death (Item 23a) (Tide, Print) 31 Beyerly Calkins M.D. DEC 1 0 2004

Registrar

**Funeral** 

Director

in then "neturel", or Items 23e or 28e-f ehow the Medical Examiner must be notified at

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Importent: If item 27 is marked other then any injury or other treumatic event, the Me

**Physician** 

/Medical

Examiner

for use as the burial-transit the attending physician and

has page 2

this

death.

To the Hospital or Attenwithin 24 hours after death To the Funerel Director:

completely filled in by the funeral director,

The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

Donegan, Michael 11-30.04 2: 20AM Baltimore. Maryland 21215-0036

		1 - For Stata Registrar				partment of I e <i>rtificate of</i>				200	) la	3922
Physic	ian	Decedent's Name (First, Michael Eugen						2. Date of D Month	1		Year	3. Time of Death
/Medi Exami		4a. Facility Name (If not institut				4b. City, Town,	or Location of Death		$\overline{}$	30, 20		2:20 a.
		Homewood Nurs	ing Home				amsport			Washi		n
Funeral Director		5. Social Security Number 220–10–3922	6. Sex 1 ⊠ M 2 □ F		n yrs. last birthda 83 Yrs.	y) If Under 1 Year Months Days		8. Date of B (Month, I June	$\frac{1}{25}$	1921	9. Birthpl Count Mar	ace (State or Foreig ry) yland
M T		Usual Residence of Decedent  10a. State 10b. Cour	nty	10	Dc. City, Town or	Location					10	d. Inside City Limit
e-f sh	tor	Maryland Was	hington			Hagersto	wn					1 ∐Yes 2⊠N
ene. then "natural", or items 23e or 28e-f show na Medical Evantiner must be notified ut	Dire	10e. Street and Number				10f. Zip Code	017/0		10g. (	Citizen of Wh	nat Count	ry?
ns 23e	eral	17920 Golf Vi		ecedent Eve	er in U.S. 11	Was Decedent of I	21740	necify Yes or N	lo.	USA 14. Race	America	n Indian
Department of health and Mental Hygiene. Importent: if item 27 is marked other then "natural", or items 23e or 28e-f show amyorient: if item 27 is marked other then the "natural" or other treumatic event, the Medical Examinat must be notified ut once.	Completed by Funeral Directo	1 ☐ Never Married 2 🖔 M 3 ☐ Widowed 4 ☐ Divorc	arried Armed  1 X Yes	Forces?	w II	3. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 🛣 No		Rican, etc.)	.0-	Black,	White, e	ite.
natur	eted	15. Deced (Specify only high	ent's Education hest grade completed	d)	16a. Dec	cedent's Usual Occup ve kind of work done	pation during most of wor	kina	16b.	Kind of Busi	iness/Ind	ustry
then he we	Jdwc	Elementary/Secondary (0-12		(1-4or 5+)		ve kind of work done . DO NOT use retire ision man				railro	oad	
other vent, I	3e C	17. Father's Name (First, Middle					18. Mother's Nam	ne (First, Middl				
arked	To Be	Michael L. Do					Mary B	. Widmy	er			
T is m treum		19a. Informant's Name/Relatio Peggy Donegan				iling Address (Street $20~\mathrm{Go1f}~\mathrm{V}$						,
item 2 other	1	20a. Method of Disposition			20b. Place of Dis	position (Name of rematory or other pla	1	Date	_	Location - Ci		
ent: n ury or		1 XBurial 2 □ Cremation 1 4 □ Donation 5 □ Other		m State		11 Cemete	· · · · · · · · · · · · · · · · · · ·	/04	На	gersto	own,	Maryland
any inj once.		21. Signal Funeral Service	ce Licensee	m.		22. Name and Addre	_	MINNICH				
		23a. Part1. Enter the disease,	or complications that	a used the	death. Do no e		1son B1vd ng. such as cardiac			own, M		Approximate
ician		shock, or heart failure. Li Immediate Cause (Final disease or condition	ist only one cause or	e ch line.	271/1	Acous	-11				1.0	Interval Between Onset and Death
dical niner		resulting in death)	a	Vor on a	-11						1.0	- 12 mos
				Di as a co	onsequence of):	1.000	10-0190	a court				
	ē	Sequentially list conditions, if any, leading to immediate	b. Du	oon	onsequence of):	INTA	KE	-				2 LUONAE
ransit	aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Conditions of that initiated events	b	oon	Onas	- (NTA)	KE				1	ELLIONIAE 37 LANC
	I Examiner	manac (manage of signity	b Dui	Oon (or as a co	Onas	Smort	KE S	-				Eluonae 370ax
s the burial-transit	m	that initiated events	b Dui	Oon (or as a co	ONAT onsequence of):	- (NTA)	KE S				1	Eluonae 374(
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Registrar DHMH 17 Rev 1/2001

Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Day **Physician** Durning 1006 AM Michael 28 2004 I Wember /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. October 17,1947 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X**□M 2□F Months 57 ∀ïrginia 215-44-7590 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show rthan "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at 1 Yes 2 □ No Maryland Director Washington Hagerstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 363-A Woodpoint Avenue 21740 U.S.A. filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 1969-1971 Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Salesman Water Conditioning Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental int: If item 27 Is marked o Charles Martin Durning ျှ Norma Grace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 363-A Woodpoint Avenue, Hagerstown, Maryland 21740 Wife Vicki L. Durning or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 □ Burial 2 ★Cremation 3 □ Removal from State Date 20c. Location - City or Town, State permit. Page Department of Important: If any injury or 12-02-04 Hagerstown Crematory Hagerstown, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Andrew K. Coffman Funeral Home, Inc.

40 Fast Antietam Street, Hagerstown,

Shock, or heart failure. List only one cau g on each line. Md. 21740 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ou lmonary dio /Medical **Examiner** therosc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): ed by the attending physician detached for use as the buria Division of Vital Records, P.O. Box 68760, Physician/Medlcal IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 🗆 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 2 No 1 🗌 Yes 2□ No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 2 1 Yes 2 No 1 Inpatient 3 DOA filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of cert H40884 30. Name and addr ass death (Item 23a) (Type, Print) E. Antietam St. Hagerstown MD 21740 0,0. FACET Momas 31. Date filed (Month, Da 32. Registrar's Signature State Registrar

			1 - State of N	Maryland / Dep Ce	artment of Health and Nertificate of Death			39229
			Decedent's Name (First, Middle, Last)		ranoate of Beatif	2. Date of Death		3. Time of Death
	Physici /Medio		Charles Leo	Dyson		Month November	Day Year 27, 2004	9:50 a.m.
	Examir		4a. Facility Name (If not institution, give street and number	or)	4b. City, Town, or Location of Death		4c. County of Death	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
		*	Bayside Care Center  5. Social Security Number 6. Sex 7	A (la con la A blabala	Lexington Pa		St. Mary	
ı	Funeral. Director		5. Social Security Number 6. Sex 1 ■ M 2 □ F	Age (In yrs. last birthday, Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) Countr	
	ס		Usual Residence of Decedent	82		April 15	,1922   Maryl	and
	arylar show		10a. State 10b. County	10c. City, Town or L	ocation		100	d. Inside City Limits
	he M	Director	Maryland St. Mary's		Park Hall			1 ☐ Yes 2 🐼 No
	with t		10e. Street and Number 47870 Park Hall Road		10f. Zip Code 20667		g. Citizen of What Countr	•
	n 72 hours after death with the Maryland "natural", or items 23a or 28a-1 show adical Examiner must be notified at	Funeral	11. Marital Status 12. Was Decede		Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	United State	
9	or ite	Fur	Armed Force 1 Never Married 2 Married 1 Yes 2	s? ∃No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, et	c.
21215-0036	urat',	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Date:	s:	1 ☐ Yes 2 🖀 No Specify:		Specify: Blacl	K
15-	□ 0	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Give	edent's Usual Occupation a kind of work done during most of work DO NOT use retired)	ing 16	6b. Kind of Business/Indu	istry
212	filed within Hygiene. other than "	omp	Elementary/Secondary (0-12) College (1-4c	r 5+)	ler Attendant		U.S. Govern	ment
br	Hyg the ant,	Be C	17. Father's Name (First, Middle, Last)	1 501		e (First, Middle, Ma		ille ii C
ylaı		ToE	Thomas Dyson		Luc	y Barnes		
Maryland	2 shoul n and Me ia mark raumati		19a. Informant's Name/Relationship (Type, Print)		ing Address (Street and Number or Run			
	s 1 and 2 should if Health and Mer item 27 ia marke other traumatic		Virgie Mary Dyson / Wife  20a. Method of Disposition	47870 20b. Place of Dispo	Park Hall Road, I			
Baltimore,	9 = 5		1 de Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, cre	matory or other place)		oc. Location - City or Town	
Ħ	mit. Parantimen ortant: Injury	1	' 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License	Charles	Memorial Gdns 12–4 2. Name and Address of Facility Bri	-2004 L	eonardtown,	Maryland
ñ	Depa Depa Impo any ir	ar I	David A. Goff	01095 2	2955 Hollywood Roa	nsileid. Leona	runeral Home rdtown, MD 2	20650-0279
Е			23a. Part1. Enter the disease, or comblications that caus shock, or heart failure. List only one cause on each	ed the death. Do not en	ter the mode of dying, such as cardiac	or respiratory arres	t. A	Approximate nterval Between
	Priysician	or 1	Immediate Cause (Final disease or condition	cerebr				Onset and Death
	/Medical Examiner		resulting in death)  Due to (or a	as a consequence of):		lusia (Stro	6.)	
H	- 1	-	Sequentially list conditions, and any, leading to himselfield.	is a consequence of	V	Social	, va	
	uted d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	.,				
o	an and rial-tra		resulting in death \ I as t	s a consequence of):				
68760,	ficate be executed physician and s the burial-transit	edlcal	d.					
_	ertific ding p		IF FEMALE:					
Вох	death certif e attending id for use a	cian	In the past 12 months?	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Da	
P.O.	that the death certif ed by the attending detached for use a	Physician/M	1 Yes 2 No 9 Unknown 9 Unknown	at time of death 32	Other (specify)			
	s un e	by P	Part II. Other significant conditions contributing to death	but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	cco use contribute to the	cause of death?
ord	w require been sig should b	ted	farhinsons Dese	ore		1 ☐ Yes	2 ☐ No 3 ☐ Probab	ly A Unknown
Vital Records,	has be	Completed	GERD			24a. Was an autopsy	24b. Were autopsy	y findings available letion of cause of
E	That are					performe 1 ☐ Yes 2 2	d? death?	No
<u>Ş</u>	aician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?  1  Yes 2  Hospital: 1  Inna		26. Place of Death			
of	£ 5 =	n: To	27. Manner of Death 28a. Date of In	jury 28b. Time of	it 3 DOA 4 34 Sing Hot	ne 5 ☐ Residend 28d. Describe how	ee 6 ☐Other (Specify)	
Division	l or Attending I after death. Director: After in by the funer	Certification:	1 Actural 5 ☐ Pending (Month, D 2 ☐ Accident investigation	ay Year) Injury	Work? M 1 ☐ Yes 2 ☐ No			
Σ	- 9 -	rtific	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of I building,	njury - At home, farm, str etc. (Specify)	eet, factory, office	28f. Location (Stree City or Town, 3	et and Number or Rural R State)	loute Number,
	pital o							
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only 2 Medical Examiner: On the basis one)	of examination and/or in	h occurred at the time, date and place, a vestigation, in my opinion, death occurr	and due to the caused at the time, date	se(s) and manner as state a and place, and due to th	ed. e cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	, actori	29c. License number	29d.	. Date signed (Month, De	y, Year)
	5				119917		11/29/04	•
4	11			death (Item 23a) (Type,				
	`		James Boyd, M.D. 234	15 Three No	otch Road Maryland	20619		
	CA	е	31. Date filed (Month, Days) ar 20032. Regis	ar's Signature	8-11-			
	Stat Registra		MA A D A CHAR PY	Color De	GOSCO			

				e of Maryland / Depa			ntal Hygie	ne	
			1 - State Registrar	Cei	rtificate of Dea		Reg.	No2004	30230
ı	Physici		Decedent's Name (First, Middle, Last)     SEWARD	J. DIMM	IE	2		Day Year 6,2004	5:22P M
	/Medio Examin		4a. Facility Name (If not institution, give street an		4b. City, Town, or Loca	ation of Death		4c. County of Death	3:22P
	LAdiiii	CI	Washington Advent		Takoma 1			Montgom	2rv
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If U	Under 24 Hrs. 8	. Date of Birth (Month, Day, Ye	ar) 9. Birthp	lace (State or Foreign
	Director		214-28-4127 1 Mm 2 D	F 76 Yrs.		I.M.	lay26,1	928   Vir	ginia
	land ow		10a. State 10b. County	10c. City, Town or Lo	ecation			1	Od. Inside City Limits
	Man	tor	MD Montgomery	y Silve	r Spring				1 <b>x</b> Yes 2 □ No
	th the	Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Cour	try?
	23e d		15728 Bradford Ro	oad	2090	06		U.S.A.	
	er deg	Funerai	Arme	Decedent Ever in U.S. 13.1	Was Decedent of Hispan f Yes, specify Cuban, Me	nic Origin? (Specif exican, Puerto Ric	y Yes or No- can, etc.)	14. Race - Americ Black, White,	
36	irs aft	by F		Yes 2 No 1946- is, Give	1 ☐ Yes 2 ☐No Sp	ecify:		Specify: B	lack
9	within 72 hours after death with the Maryland ene. than "natural", or itams 23e or 28e-f show to Medical Examiner must be notified at	ted	15. Decedent's Education	1931 16a. Dece	dent's Usual Occupation		16b	. Kind of Business/Ind	lustry
218	ithin 7 19. 1881 "r	Completed	(Specify only highest grade completed and secondary (0-12)  Elementary/Secondary (0-12)  Colleted and secondary (0-12)	ege (1-4or 5+)	kind of work done during DO NOT use retired)			John Hopl	cins
7	led wi lygien har th			Pyrs Adm:	inistrativ			Laborato	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: if item 27 is marked other than "natural", or itams 23e or 28a-f show any injury ocother traumatic event. It a Medical Examiner must be notified at once.	Be	17. Father's Name (First, Middle, Last)	. •	18. /		First, Middle, Maid		
Ž	thould id Me mark matic	2	Joseph W. Dimm		ng Address (Street and N		M. And		Code
Ma	nd 2 s lith an 27 is		Ricardo D. Wooten-	,					,
ē,	s 1 ar if Hea item		20a. Method of Disposition	20b. Place of Dispo		Date		Location - City or To	
E	Page nent o		XXBurial 2 ☐ Cremation 3 ☐ Removal '4 ☐ Donation 5 ☐ Other (Specify)	from State	Church Ce	-m 11/1	3/04 Pa	almyra. V	7 Z\
ati	mit. apartm poerts ny inju		3 Signature of Funeral Service Licensee	1 1 22	. Name and Address of I	Facility Sno	wden Fi	neral Ho	ome P.A.
8	89 E 29		COPYE TO	mouelle:	246 N. Was	shingto	n St Ro		
П			23a. Part1. Enter the disease, or complications to shock, or heart failure. List only one cause	that caused the death. Do not ento o on each line.	er the mode of dying, suc	ch as cardiac or re	espiratory arrest,		Approximate Interval Between Onset and Death
	Priysician /Medical		Immediate Cause (Final disease or condition resulting in death)	ACUTE MYOCARD	IAL INFARO	CTION			5 days
	Examiner		Du Du	ue to (or as a consequence of): ATHEROSCLEROT	C CAPDIO	INCCIII N	D DICE?	CE	Morama
		er	Sequentially list conditions D	ue to (or as a consequence of):	IC CARDIO	ASCULA	K DISEF	436	Years
	uted id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events						
Ó,	e exection are are are are are are are are are are	Exa	annulaine in denate \ L and	ue to (or as a consequence of):					
8760,	cate be executed physician and the burial-transit	dicai	d						
9		/Mec	IF FEMALE:	s, outcome of pregnancy					
Вох	The law requires that the death certifitate has been signed by the attending lage 2 should be detached for use as	Physician/Me	in the past 12 months?	_ive birth 2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ry Day Year
o.	that the di ed by the detached	ysic		Unknown	Cities (specify)				
<u>α</u>	es that igned b be deta	by Pi	Part II. Other significant conditions contributing	to death but not resulting in the un	nderlying cause given in f	Part I.	23e. Did tobacc	o use contribute to th	e cause of death?
rds	w require been sig should b	ed b	Cardiogenic Shock	Severe Aort:	ic Stenosi	is	1 🗆 Yes	2 ☐ No 3 ☐ Proba	ably 4 🔀 Unknown
eco	has been ge 2 shoul	piet	Renal Insufficien	ncy			24a. Was an autopsy	24b. Were autop	sy findings available apletion of cause of
Vital Records,		Completed	Chronic_ischemic	cardiomyopath	ıv		performed' 1 ☐ Yes 2 ☐	?   death?	
/ita	cian: ertific ector,	Be	25. Was case referred to medical examiner?		26.	Place of Death (C	Check only one)		
	Physical this of	2	1 ☐ Yes 2 ☑No Hospital:	1 Propatient 2 ER/Outpatien  Date of Injury 28b. Time of			5 Residence	6 ☐Other (Specify	)
Division of	ding h. After funer	Certification:		(Month, Day Year)	28c. Injury at Work? M 1 ☐ Yes		i. Describe now in	ijury occurred	
/isi	or Attano after death Director: In by the	ifica	3 Suicide 6 Could not be	Place of Injury - At home, farm, str				and Number or Rural	Route Number,
ă	al or A s after al Direct	Cert	4 Homicide	building, etc. (Specify)			City or Town, Sta	afe)	
	To the Hospital or Attanding Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifying Physician: T	o the best of my knowledge, death the basis of examination and/or inv	occurred at the time, da	ate and place, and	I due to the cause	(s) and manner as sta	ated.
	the H in 24 the F iplete	ledicai	one) and	manner stated.					
	To with	Σ	29b. Signature and title of certifier		29c. License num			Date signed (Month, E	
	10		roger   Cert	nan my	D2879	₹	NC	vember 2	2, 2004
	V	-	30. Name and address of person who completed Mr. Roger Leonard,			rd, Roc	kville.	MD 2085	2
	Sta	te		32. Registrar's Signature	4				
	Registr	ar	NOV 2 4 2004	Deneva B	Sporth				

			1 - For Stata Registrar		State of	Maryland.		artment o			/lental H	ygiene Reg. No		1	0000
	Physici /Medic		Decedent's Name (First)	Middle, La	,	OUGHERT	Y				2. Date of I Month NOV.	Death Da	<del>~ U</del> U	ear <b>)4</b>	7:00 A M
	Examir		4a. Facility Name (If not in:	stitution, gi	ve street and numb	ber)		4b. City, Tow	n, or Location	of Death		4c	. County of	Death	
			HILLHAVE	-					ADELPH				PRINC	E GE	ORGES
	Funeral Director		5. Social Security Number  072-14-416  Usual Residence of Deced	L	Sex 7. 1 □ M 2 <b>X</b> □ F	. Age (In yrs. last	Yrs.	If Under 1 Ye Months Da		Min.	8. Date of 8 (Month, 8	3, 1	919	Count	ace (State or Foreign try) RGINIA
	show			County		10c. City, T	own or Lo	ocation						10	Od. Inside City Limits
	Man Ff sh	ţō	MD. PR	INCE	GEORGES			НУАТ"	rsvill	E					1 X Yes 2 □ No
	h the	Director	10e. Street and Number					10f. Zip Coo				10g. Ci	tizen of Wha	at Count	try?
	23a c	<u>e</u>	7020 AD	ELPHI	RD.				20782				U.S.	Α.	
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show among injury or other traumatic event. The Medical Example and once.	by Funeral	11. Marital Status  1 Never Married 21  3 Widowed 4 Di	-	12. Was Deced Armed Forc 1 Tes 2 If Yes, Give Year or Date	<b>™</b> No		Was Decedent If Yes, specify ( 1 ☐ Yes 2 🔀	uban, Mexic	an, Puerto	pecify Yes or No Rican, etc.)	10-	14. Race - Black, \ Specify:	America White, e	etc.
5-0	72 ho	etec		cedent's E	ducation rade completed)	1	6a. Dece	dent's Usual Oc kind of work do	cupation	st of work	tina	16b. K	ind of Busin		
2121	within ene. than "	Completed	Elementary/Secondary (	-	College (1-4	tor 5+)	life.	DO NOT use re	tired)		9				
	filed w Hygier Ithar ti		17. Father's Name (First, A	liddlo Las	2		I	DENTAL A			- /5: > > 1:		ENTIST	OF	FICE
Maryland	t be find had and ot	Be				T T 7737			18. Moti		e (First, Midd				
Z Z	should nd Men marka umatic	2	WILLIA 19a. Informant's Name/Re			ALLEN	10b Mailir	ng Address (Str	not and Mum		THLEEN		BROMBY		0-4-1
Ma	and 2 sealth an n 27 is		JAMES M. I				7020								
ore,	os 1 ar of Hea itam		20a. Method of Disposition			20b. Place	e of Dispo	sition (Name of			ATTSVI Date	-	ocation - Cit		
Ë	Pages nent of I			1 Burial 2 Temation 3 Removal from State 4 Donation 5 Other (Specify)  CHAMBERS CREMATORY 11-23-2004 RIVERDALE, MD.											
Baltimore,	CHAMBERS CREMATORY  21. Signature of Funeral Service Licensee  22. Name and Address of Fi  CHAMBERS FUNE  5801 CLEVELAN									AL HO	ME & C	REMA'	CORIUM	ſ,P.,	Α.
В			23a. Part1. Enter the dises	ase, or con	nplications that cau	used the death. E	Do not ent	er the mode of	tying, such a	s cardiac	or respiratory	arrest,			Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition		METAS	STATIC CA	ANCER	R OF UNI	NOWN	PRTMA	RY				Onset and Death
	/Medical Examiner		resulting in death)	-	- u	r as a consequen									
ĥ	LAdimilei	L	Sequentially list conditions		b		-								
	led isit	nine	cause. Enter Underlying Cause (Disease or injury	·	Due to los	r as a consequent	ce orli:								
	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last		c. Due to (or	as a consequent	ce of):			_	_			-	
68760,	siciar buris	al		l			,								
687		edlcal			0.										
.O. Box	at the death certificate be executed by the attending physician and tached for use as the burial-transit	Physiclan/M	IF FEMALE:  23b. Was decedent pregnation the past 12 months 1 ☐ Yes 2 MNo 9 ☐ Unknown			h 2 ☐ Fetal dea nt at time of death	ath 3	Ectopic pregna Other (specify					23d. Date of Month		y Day Year
٣.	law requires that the as been signed by th 2 should be detache	by Pl	Part II. Other significant c	onditions	contributing to deat	th but not resultin	g in the ur	nderlying cause	given in Part	1.	23e. Did	tobacco u	ıse contribu	te to the	cause of death?
rds	quire on sig uld b		CORONARY	ARTEI	RY_DISEAS	Е, НҮРЕ	RTENS	ION			1 🗆	Yes 2	ŪNo 3[	] Proba	bly 4 □Unknown
Records,	aw requir is been s 2 should	Completed	OSTEOARTI	RTTT	S. BREAST	' CANCER.	. COT	ON CANO	ER		24a. Wa		24b. Wer	e autop:	sy findings available
R	0 - 0	E O						02			per	opsy ormed?	deat		pletion of cause of
Vital		a)	25. Was case referred to n	redical					26. Plac	e of Deat	h (Check only	2 No		103 2	:
Į (	d is	To B	examiner? 1 ☐ Yes 2 <b>聚</b> No		Hospital: 1 Inp	atient 2 ER/	Outpatien	t 3 DOA	7th on		me 5 Res		6 □Other (S	Specify)	
n of			27. Manner of Death 1 🛣 Natural 5 🔲	Pending	28a. Date of (Month,	Injury 28t Day Year)	b. Time of Injury	28c. Ir	jury at vork?		28d. Describe	how injur	y occurred		
sio		catl	2 Accident investigation M 1 Yes 2 No							]No					
Division	in the	Ţ.	3 Suicide 6 4 Homicide	determined	289. Place of	Injury - At home, , etc. (Specify)	, farm, stre	eet, factory, office	<b>(9</b>			(Street an own, State		r Rural	Route Number,
	spital ours a naral L		00-00-Win #F0 0		<u> </u>										
	Ho Hu Hu ely	edical	29a. Certifier 15 Ce (Check only 2 Me one)	dical Exa	hysician: To the be miner: On the basi and manner	is of examination	and/or inv	occurred at the restigation, in m	time, date a y opinion, de	nd place, ath occur	and due to the red at the time	cause(s) , date and	and manne I place, and	r as sta due to t	ted. he cause(s)
	To tha Hos within 24 h To tha Fun completely	Me	29b. Signature and title of	envier	11			29c. Lice	ense number			29d. Dat	e signed (M	onth, D	ay, Year)
	3			17	MAD	4		Т	55559			N	IOV. 2	2. 3	2004
	حہ		30. Name and address of p	erson who	completed cause	of death (Item 23:	a) (Type,					L	2	_, /	
			THOMAS E.	MASI	LEN, M.D.	75	525 G	REENWAY	CENTE	ER DR	., GRE	ENBEL	T, MD	. 20	0770
	Sta		31. Date filed (Month, Day,			istrar's Signature									
2.1	Registr	ar	140 A	N T (	.004   🗚	neve	J	Some	In A						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Cleveland Dewey Dixon November 21, 2004 11:21 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F 217-36-9758 63 Yrs. Director 1941 Washington, DC July 31. Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic evant, the Mudical Exprining must be notified at once. 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Lothian Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 970 Upper Pindell 20711 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo White Specify: 3 Widowed 4 NDivorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Racecar Builder Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Maurice Dixon Doris Rebecca Hook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vickie Bishop (daughter) 970 Upper Pendell Road Lothian, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Nov 30. 1 ☐ Burial 2 Tremation 3 ☐ Removal from State 4 ☐ Donation Lee Crematory 5 Other (Specify) 2004 Clinton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, PA Gary J. Goff 8125 Southern Maryland Blvd. Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) an(PV /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner the attending physician and ned for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? res 2 No 1 ☐ Yes 1 Tyes 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient P 1 Inpatient 3 DOA After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1, Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: Aft 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1/2 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 30. Name and appress of person who completed cause of death (Item 23a) (Type, Print) 400 Bestyde pd 4300 Annapolis Kein Knort MU 32. Registrate Signature

104 Blosser H. Spall 31. Date filed (Month, Day, Year) State 2004 Registra

State of Maryland / Department of Health and Mental Hygiene Reg. 4. U 0 4 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month November 27, 2004 **Physician** Francis Howard Deremer 9:52 P M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cumberland Villa Nursing Center Cumberland Allegany If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth O2/28/1924 **Funeral**  Birthplace (State or Foreign Country) Months Days Hours 1∭M 2□F 219-14-5572 80 Director Mary land Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 te marked other then "naturel", or Items 23e or 28e-f ehow other treumatic event, the Madical Examiner must be multilled at 1 ☐ Yes 2 🛣 No Director Allegany Corriganville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10909 Poe Avenue 21524 USA Funeral 12. Was Decedent Ever in U.S. Amed Forces?

12 Yes 2 No 1943 -11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiene. nent of Health and Mental Hygiene. ent: If Item 27 ie marked other then "naturel", or Ite 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed by If Yes, Give Year or Dates: Specify: 3 ₺ Widowed 4 Divorced White 1946 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Attorney Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Delmar Deremer Rosetta Virginia House Francis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randi Countryman / daughter 404 National Highway, LaVale, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 → Burial 2 □ Cremation 3 □ Removal from State ö permit. Page Department of Importent: If any injury or once. Sunset Memorial Park | 11/30/2004 ` 4 □Donation 5 □ Other (Specify) Cumberland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, 1.A. 404 Decatur Street, Cumberland, MD 23a. Part1. Enter the disease, or complications that based the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical ue ( as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last arlenson taw requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 🗆 Unknown has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 @tinknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 NO 2 ANO 1 Yes of or Attending Physicien: after death. Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ö 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending М 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a
To the Funerel C
completely filled To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0054411 November 30, 2004 IVA 30. Na ne and address of per on who completed cause of death (Item 23a) (Type, NLS Calkins, M.D., 500 Memorial Avenue, Cumberland, Maryland Beverly 31. Date filed (Month) 3. Registrar's Signature State anks/ Registrar

		1 - For State Registrer		-	artment of rtificate of		-	Reg. Ng. 0	
Physici /Medi Examir	cal	Decedent's Name (First, Middle, Last,     George David     As. Facility Name (If not institution, give)			4b. City, Town,	or Location of Dea			3. Time of Death 2004 7:50 a
Funeral	P	12801 Meadowbrool  5. Social Security Number 6. Sec	7. Age	(In yrs. last birthday					Charles  9. Birthplace (State or Foreign Country)
Director		579–20–2401  Usual Residence of Decedent  10a, State 10b, County	]M 2□F	84 Yrs.		TIOUIS WIII	8/22/1	920	VA
the Maryl 28a-f sho	Director	MD Char				ldorf		10g. Citizen of W	1 <b>X</b> Yes 2 □ N
3a or		12801 Meadowbrook	Lane			0601		USA	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deparmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The Medical Evertical Internation once.	by Funeral		12. Was Decedent Ev Armed Forces? 1 A Yes 2 No If Yes, Give Year or Dates:			Hispanic Origin? (S ban, Mexican, Pue	Specify Yes or No to Rican, etc.)	o- 14. Race	e - American Indian, k, White, etc.
d within 72 hours att giene. er than "natural; or	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	16a. Dece (Give	DO NOT use retin	eduring most of wo ed)		16b. Kind of Bu	
Ind y latte & I	Be	8 17. Father's Name (First, Middle, Last)			Mechar	18. Mother's Na	me (First, Middle	U.S. GOV , Maiden Surnam	
hould d Mer marke matic	70	Solomon David  19a. Informant's Name/Relationship (Ty)	no Orint)	40h M-11	111 (0)	Janet F			
nd 2 s lith an 27 is r traur		Ethel Ramsey/ Daug				tand Number or R Drive,			
Definition of the permit. Pages 1 ar Department of Heal mportant: If item 2 any injury or other 2006.	1 3	20a. Method of Disposition	ITOCI	20b. Place of Disp cemetery, cre			Date		City or Town, State
Pages nent of h ant: If its		1   Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)	emoval from State	So. Memo.	-		24/2004	Dunkirk,	Maryland
permit. Departm Importa any inju		21. Signature of Faneral Service license	90	2	2. Name and Addr	ess of Engility	Raymond-		eral Home, P.
Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)		pe death. Do not en $PNEC$		ing, such as cardia			Approximate Interval Between Onset and Death
Examiner	er	Sequentially list conditions, if any, leading to immediate	.=====	consequence of):	CATIO	v ~			2 wks
ate be executed hysician and he burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause Enter Indestruing Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a o	A L 2/A	EIME	RS L	2		4 tans
death certific e attending pl	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of 1 □ Live birth 2   4 □ Pregnant at tir 9 □ Unknown	Fetal death 3	Ectopic pregnanc Other (specify)	cy .		23d. Date Mon	of delivery th Day Year
ed Be	by	Part II. Other significant conditions con	27 017	- 0150		ven in Part I.			bute to the cause of death?  Probably 4 □Unknown
sician: The law requires that the centificate has been signed by the rector, page 2 should be detache	Completed	OSTLOA	ATUA	1765			24a. Was autop perfo 1 \( \text{Yes}	osy pr ormed?_ de	ere autopsy findings available for to completion of cause of eath?  Yes 2 \( \sum \) No
ding Phys h. After this funeral di	atlon: To Be	25. Was case referred to medical examiner?  1 Yes 2 No H  27. Manner of Death  1 Natural 5 Pending investigation	ospital: 1  Inpatient 28a. Date of Injury (Month, Day Y	2 ER/Outpatier 28b. Time of Injury	28c. Inju Wo	her: 4 ☐ Nursing H			
in Dir	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (	- At home, farm, sti Specify)	eet, factory, office		28f. Location (S City or Tox	Street and Number wn, State)	r or Rural Route Number,
To the Hospital or within 24 hours after To the Funeral Dir completely filled in I	edical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Exemination	icien: To the best of r er: On the basis of ex and manner stated	(amination and/or in	n occurred at the ti vestigation, in my	me, date and place opinion, death occu	a, and due to the durred at the time,	cause(s) and man date and place, ar	ner as stated. nd due to the cause(s)
To t with To t com	Σ	29b. Signature and title of certifier  Ruch	8	mo	29c. Licens	8 8/19		_	(Month, Day, Year)
6		30. Name and address of person who con Richard Berndorf,							

			1 - For State Registrar	State of	Marylan	id / Depa	artment of H	lealth : Death	and Me		iene g. No.	4	392	36
			Decedent's Name (First, Middle, La.	st)						2. Date of Deat	h		3. Time o	of Death
	Physici /Medio		Donald A	rmour	Emn	nart			D	Month December	Day 5. 20	Year 004	6:15	a.m <sup>M</sup>
	Examir		4a. Facility Name (If not institution, give	street and numb	oer)		4b. City, Town, or	Location			4c. Count			C
			Bayside Care	Center			Lexin	gton	Park		St.	Marv	's	
	Funeral		5. Social Security Number 6. S	ex 7.	Age (In yrs.	**	If Under 1 Year Months Days	If Under Hours	24 Hrs. 8	B. Date of Birth (Month, Day,	Year)	9. Birth	place (State	or Foreign
	Director		212-22-8146	M 2□F	76	Yrs.	Monato Bayo	110010		ar. 4,			y1and	
	and		Usual Residence of Decedent  10a. State 10b. County		10c, Cit	v. Town or Lo	cation						10d. Inside C	`ih. Limite
	Manyl f sho	5	Manual and I											s 2@No
	28e-	Director	Maryland St. M	ary's			Great M:	IIIS		10	0g. Citizen of	What Cou		<u> </u>
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	death ms 2:	Funerai	11. Marital Status	12. Was Decede	ent Ever in U.		Was Decedent of Hi	spanic Or	iain? (Spec	ifv Yes or No-	United		tes ican Indian,	
136	be filed within 72 hours after death with the Maryland ital Hygiene. In the manyland other then "neturel", or Items 23a or 28e-f show event, the Medical Examena, must be indiffed at	by Fur	1 ☐ Never Married 2 ☐ Married 3   Widowed 4 ☐ Divorced	Armed Force 1 Tyes 2 If Yes, Give Year or Date	<b>≅</b> No	"	f Yes, specify Cuba I□ Yes 2 No	n, Mexicar Specify:	n, Puerto Ri	ican, etc.)		ck, White		
212-0036	2 hou	ed	15. Decedent's Ed	lucation		16a, Dece	lent's Usual Occupa	ation	_		16b. Kind of B	usiness/fr	ndustry	
2	within 72 ene. then "net	Completed	(Specify only highest gra	de completed)	1245.)	(Give	kind of work done of OO NOT use retired	lurina mas	at of working	7	TOD. KING OF B	uaii 1633/11	dustry	
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9	il Hygid other	Ø	17. Father's Name (First, Middle, Last)						er's Name (	First, Middle, N			Limen	L
yland	fental fental rked o	To B	Armour Dallas	Emmart					Anne	ette R.	Frock			
az	should have	-	19a. Informant's Name/Relationship (7	Type, Print)		19b. Mailin	g Address (Street a	and Numbe	10			State, Zij	Code)	
Z	alth alth		Thomas H. Emmart	/ Son		27575	Brothers	Lane	e. Mec	chanics	ville.	MD 2	0659	
e e	as 1 a		20a. Method of Disposition			lace of Dispo	sition (Name of natory or other place		Dat		Oc. Location			
Ĕ	Page nent ant: If		1 ☐ Burial 2 <b>@</b> Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify		ara		d-Echols		12-7-2	2004 C	harloti	-е На	11. MI	)
Бащтог	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked eny injury or other treumatic evance.	ľ	21. Signature of Funeral Service Licen	2		22	. Name and Addres	s of Facili	y Brin	sfield	Funera	1 Ho	me. P.	Α
<u> </u>	897289			ield, Jr		052 ZZ	955 Holly	wood	Road.	Leona	rdtown.	MD	20650-	-0279
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that cau	sed the death	n. Do not ente	er the mode of dying	g, such as	cardiac or r	respiratory arre	st, q	STREET	Approximat Interval Bet	te
	Physician		Immediate Cause (Final disease or condition	A	contr	Asp	mitro	~	Pnen	mon	~		Onset and	
	/Medical		resulting in death)	Due to (or	as a consequ	uence of:								
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L	The law requires that the ate has been signed by th page 2 should be detache	by Pł	Part II. Other significant conditions of	ontributing to deat	h but not resu	alting in the un	derlying cause give	n in Part I.		23e. Did toba	acco use cont	ribute to tl	ne cause of c	death?
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วี	w rec	Completed	14. 1.		Acres	11-	11/10			24a. Was an	24h \	Nere auto	psy findings	available
ב	he la e has age 2	duc	Menon	/	0-00	w we	o Ullin			autopsy perform	ed?	prior to co death?	mpletion of c	ause of
l a	ifficat or, pë	e Cc	25. Was case referred to medical					00 Diana	of Doobby (			Yes	2000	
	s cert	0 0	examiner?	Hospital:	ationt 2 🗆 I	ER/Outpatient	3□ DOA Othe	-		Check only one 5 ☐ Resider				
5	g Phy er thi eral c	n:T	27. Manner of Death	28a. Date of I	njury	28b. Time of	28c. injury	at		d. Describe hov			/)	
5	ath. r: Aft	atio	Natural 5 ☐ Pending 2 ☐ Accident investigation		Day Year)	Injury	Work M 1 □ Y	? ′es 2 🗆 !	No					
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5	s afte	Certification:	- I Hormondo	building,	, etc. <i>(Specify</i>	7				City or Town,	Stare)			
	To the Hospitel or Attending Physicien: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2 completely filled in by the funeral director, page 2.	edical	(Check only Z 2 Medical Exam	iner: On the past	S of examinat	wledge, death ion and/or inv	occurred at the time	e, date and	d place, and	d due to the cau	use(s) and ma	nner as st	ated.	;)
	thin 2 the mple	Med	29b. Signature and title of certifier	and manner	stated.		29c. License				d. Date signed			
	F 3 F 8			1			D/9			29	i L/1/	m (1	Jay, 15d1)	
2	SPE		20 1		/			116			1741	7		
	1 le	13	30. N. 3 addrer of verson who	11	of death (Item				• •		25	0065	2	
	Sta	te	31. Date filed (Month, Day, Year)	32 Regi	strar's Signat	III a	tch Road	, Cal	11orn	ıa, Mar	yLand	20619	j	
	Registr		DEC 0	7 2004	Marine .	A. A.								
	1000			1			P**							

	1	State of Maryland / D	Department of F Certificate of		ental Hygie	/ 11 11 13	39237
Physicia	n	1. Decedent's Name (First, Middle, Last) FRANK FELDMAN			2. Date of Death Month OVEMBER	Day 21, 2004	3. Time of Death 6:21P M
/Medica Examine		4a. Facility Name (If not institution, give street and number) HOLY CROSS HOSPITAL		or Location of Death		4c. County of Death	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bird 228-26-7687 1 ₹ M 2 □ F 90	thday) If Under 1 Year Yrs. Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month Day, Y APRIL 1	(ear) 1914 WA	place (State or Foreign onto) SHINGTON, DC
Mary iding A 1 A 13-0030  1d 2 should be filed within 72 hours after death with tha Maryland the and Mental Hygiene.  27 is marked other than "nature!, or itams 23a or 28e-f show rireumatic event, the Modical Examiner must be notified at	ector	10e. Street and Number 9820 OLD SPRING ROAD  11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  7. Father's Name (First, Middle, Last) SAMUEL FELDMAN  19a. Informant's Name/Relationship (Type, Print)  EDYTHE R. FELDMAN – WIFE  20a. Method of Disposition  20b. Place of	10f. Zip Code 20 13. Was Decedent of Fif Yes, specify Cub 1 □ Yes 2 ☑ No Decedent's Usual Occup (Give kind of work done life. DO NOT use retire DENTIST  D. Mailing Address (Street 320 OLD SPRI f Disposition (Name of	opation during most of working of the second	UNI  g  If (First, Middle, Matter)  COLKER  Route Number, (CENSINGT)	g. Citizen of What Cou ITED STATE  14. Race - Amer Black, White Specify: W  Sb. Kind of Business/li DENTISTRY aiden Sumame)  City or Town, State, Zi	S OF AMERICA ican Indian, etc. HITE industry ip Code) 895
Baltimore, bernit. Pages 1 ar Department of Hea Importent: If tem any injury or othe		1 No. wind 2 Commettee 2 M Removal from State	ry, crematory or other pla AVID MEM. GA 22 Name and Addre EDWARD SA	ARD. 11/23 GEL FUNER	3/2004 AL DIRECT	FALLS CHU	RCH, VA
A LOU,  Ale ba executed  Ale burial-transit  Ale burial-transit  Ale burial-transit  Ale burial-transit  Ale burial-transit  Ale burial-transit  Ale burial-transit  Ale burial-transit  Ale burial-transit  Ale burial-transit	dical Examiner	23a Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Exist the conditions cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the conditions of t	not enter the mode of dyi  HEART F of):	ng, such as cardiac o		ILLE, MD 2	Approximate Interval Between Onset and Death 12 AMS
I HECOTGS, P.O. BOX 68 The law requires that the death certificate has been signed by the attending planes 2 should be datached for use as in	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	a 3 ⊟Ectopic pregnanc 5 □ Other (specify) _	cy		23d. Date of deli	very Day Year
uires that the signed by lid be dated	by	Part II. Other significant conditions contributing to death but not resulting i	n the underlying cause g	ven in Part I.		acco use contribute to	the cause of death?
	Completed					prior to death? SNo 1 ☐ Yes	topsy findings available ompletion of cause of
	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No  Hospital: 1★Inpatient 2 ☐ ER/Out	utnatient 3 DOA Ot	26. Place of Death			ify)
VISION OT Attending Phys r death. sctor: After this by the funeral di	atlon: To	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  2 Accident investigation	Time of 28c. Injury	28c. Injury at Work?  1 Yes 2 No			
Division tal or Attending rs after death. al Director: Afte led in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, for building, etc. (Specify)			City or Town,		
DIVISION OF To the Hospital or Attending Ph within 24 hours after death. To the Funaral Director: After th completely filled in by the funeral	fedical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledg 2 Medical Examiner: On the basis of examination are and manner stated.	nd/or investigation, in my	opinion, death occurre	ed at the time, dat	o and place, and due	to the cause(s)
Veith Conf	Σ	29b. Signature and title of certifier  D. Vulwamaduly Medaly Ms		3 464		d. Date signed (Month OVEMBER -	
12		30. Name and address of person who comfleted cause of death (Item 23a) VIKRANADITYA. D. REDDY, IIIX ROCK	(Type, Print) VIUE DIKE,	SUITE 208,		LE, ND-1	
Sta Registi		31. Date filed (Month, Day, Year)  NOV 2 4 2004  32. Registrar's Signature	G Spork				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Yeer Month Rose FINIFTER **Physician** 1:00AM Nov 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Hebrew Home of Greater Washington Rockville Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🗆 🗓 🗡 F Director May 30. Russia 212-05-4718 92 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County ns 23a or 28a-f show 1 TYes 2 No Director Potomac Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 11709 Milbern Drive 20854 United States or items 23a permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s enty injury or other traumatic event, Ita Madieti Exertiral must once. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 X No. Specify: 3 X Widowed 4 ☐ Divorced Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Clerical 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Be Lena Muchnick Harry Euchtman 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Brickman, Daughter 11709 Milbern Drive, Potomac, MD 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 11/23704 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Tifereth Israel Anshe Sphard Cemetery Rosedale, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens, e Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part1. Since the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresphock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** nest Unknown paur /Medical Due to (or as a cons nuence of): unknown **Examiner** respiration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner be executed burial-transit and Due to (or as a consequence of) Box 68760, Be Completed by Physician/Medical the that the death certificate as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Year Month Day ŏ 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Alzheimers 3 Probably 4 □Unknown Demention 1 TYes 2 X No Atherosclerosis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Hypertension 2 No 1 ☐ Yes 2) No 1 🗌 Yes of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: Other | 5 | Residence | 6 | Other (Specify) Hospital: 1 ☐ Yes 2XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred To the Hospital or Attending Injury 5 Pending investigation 1 Atural 1 □ Yes 2 □ No death. 2 Accident Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funeral Dire 4 | Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatur and title of certifier Shulpatt Hun, MD November 22,2004 D0002713

Registrar DHMH 17 Rev 1/2001

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Darks

Rockville, MD 20852

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2004

32. Registrar's Signature

Shilpa H. Amin, mD

31. Date filed (Month, Day, Year) NOV 24

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. 2.004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month **Physician** 2004 NOV. 7:20 AM FISHBURNE ALVIN /Medical 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street and number) 4c. County of Deeth Examiner Montgomery Holy Cross Hospital Silver Spring 9. Birthplace (State or Foreign Country) N. Carolina If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Aug. 9, 1944 5. Sociel Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 M M 2 □ F Yrs. 60 Director 213-76-3712 Usuel Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Merylar Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Modical Examiner must be notified as Rockville 14 Yes 2 □ No MD Director Montgomery 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 20853 U.S.A. 14306 Gaines Ave Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 Never Married 2 ☐ Married ☐ Yes 2 ☐ No f Yes, Give Specify: Black Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐XNo Specify. à lf Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Home Domestic None 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be McFarland Ethel Issac Fishburne 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) 14306 Gaines Ave Rockville, MD 20853 Ethel Fishburne- Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State P Arlington National 12/8/04 Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Snowden Funeral Home, P.A. 246 N Washington St Rockville, MD20850 246 N Washington St Roc 231 Part I. Enter the disease, or compiliations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Acute Myocardial Infarction disease or condition resulting in death) Examine Due to (or as a consequence of). Physician/Medicai Examiner Diabetes Mellitus To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the buriel-transit Due to (or as e consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury Hypertension Division of Vital Records, P.O. Box 68760, that initiated events Due to (or as a consequence of): resulting in death) Last Seizures Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ② Unknown Spastic Quadriplegia þ 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? Completed Mental Retardation completion of cause of death? 1 Yes 2X-No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2X No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 XNatural 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 22,2004 e D20274 November 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Registrar **DHMH 16 Rev 6/95** 

State

Kirti Vohra, MD 31. Dete filed (Month, Day, Year)
NOV 2 4 2004

32. Registrar's Signature

7710 Bradley Blvd Bethesda, MD 20817

State of Maryland / Department of Health and Mental Hygie Re 1

1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** HAROLD PARKER FOWLER NOVEMBER 24 2004 8:55 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. 5 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)
N. Carolina 8. Date of Birth (Month, Day, Year) FEB. 13, 1929 **Funeral** Months Days Hours 1 X M 2 □ F 75 Director 238-38-1833 Usual Residence of Decedent 10a State 10h Counts 10c. City. Town or Location 10d. Inside City Limits 28a-f show ast be rutified at Maryland Frederick Myersville 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 12271 21773 Harp Hill Rd. United States or items 23e death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) the Medical Examiner: Black, White, etc. filed within 72 hours after Yes 2 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 'netural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. U.S. Elementary/Secondary (0-12) College (1-4or 5+) Communication Specialist Federal Government s 1 and 2 should be filed wi Health and Mental Hygien tem 27 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fowler Aubrey Clyde Harriett Howe11 ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health if item 27 i Joann Wolf / Daughter 12271 Harp Hill Rd./ Myersville, Maryland 21773 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If iter eny injury or oth 1 X Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Charles Mem.Gardens 11/30/2004 Leonardtown, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Homes, P.A. Daymone 1621 Opossumtown Pike/ Frederick, MD 21702 23a. Part I there the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Frontal Parietie Nemorahic Pnysician Due thor as a consequence of): /Medical Examiner multi tocal embalic Sequentially list numbers if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Q((C) attending physician for use as the buria Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) the Records, P.O. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð anemia 1 Tes 2 No 3 Probably 4 2 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an has autopsy performed? 2**X** No 1 Tyes Division of Vital To the Hospital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural death. I Director: A d in by the fu 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11/26/04 address of person who completed cause of death (Item 23a) (Type, Print) adgetical Dive Frederick Md Ciar kousk CLNQ 31. Date filed (Month. 32. Registrar's Signature State Registrar

	•		1 - For State Registrar	State of Ma		partment of learning	Health and M	Mental Hy	giene	) I. /	2001		
	Physic /Medi		Decedent's Name (First, Middle, Las     William H	•	Friend			2. Date of De Month		Year 1.3	3. Time of Death 3:15		
	Exami		4a. Facility Name (If not institution, give			4b. City, Town, Cumber	or Location of Death		4c. County Allega	of Death	7. 10		
	Funeral Director		210-34-4333	7. Age	(In yrs. last birthda Yrs.	y) If Under 1 Year Months Days		8. Date of Bir (Month, Da Jul 6,			ce (State or Foreign		
	aryland show	_	Usual Residence of Decedent  10a. State 10b. County  MD Allegan	V	10c. City, Town or	Location Derland				10d	I. Inside City Limits		
	or 28a-f	Directo	10e. Street and Number		Cuii	10f. Zip Code			10g. Citizen of	What Country	1 Yes 2 No √?		
	within 72 hours after death with the Maryland ene. than "naturat", or Items 23a or 28a-f show ta Medical EXEIter IIIvat by neitified at	Funeral Director	320 Grand Avenue	12. Was Decedent E Armed Forces?			21502 Hispanic Origin? (Spoan, Mexican, Puerto	pecify Yes or No	)- 14. Rac Bla	SA se - American ck, White, etc			
9000	hours aft	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates: 1	957-58	1 □ Yes 2 No			Specif	white			
1215-	within 72 ene. than "nat	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		(Giv		pation during most of work d)	king	16b. Kind of B	-	stry '		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Extra frail be nutified at once.	To Be Co	17. Father's Name (First, Middle, Last) Hugh H. Friend		Labui	<u>ei                                    </u>	18. Mother's Nam						
Mary	nd 2 shouluith and Milth a	F	19a. Informant's Name/Relationship (7) Linda Friend	<sub>/рө, Print)</sub> wife	19b. Mai	iling Address (Street	and Number or Rur	al Route Number			21502		
more,	ages 1 al ent of Hea nt: If itam 'y or othe		20a. Method of Disposition  1  Burial 2  TCremation 3    1  Other (Specify,			position (Name of ematory or other pla uneral Home	ce)	Date 12/3/2004	20c. Location -		n, State MD		
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	Physician	5 17	23a. Part Enter the disease, or comp shock, or leart failure. List only of Immediate Cruse (Final disease or condition	1	he death. Do not e	108 Virg		e: Cumber or respiratory a	land, MD :	Ar	pproximate iterval Between inset and Death		
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f Vital	rysician: Th nis certificate director, paç	To Be	25. Was case referred to medical examiner? 1 \( \text{Yes} \) 2 \( \text{No} \)	lospital:	2 <b>≰</b> ER/Outpatie	ent 3 DOA Oth	26. Place of Death er: 4 ☐ Nursing Ho		ne) ence 6 □Othe	er (Specify)			
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N N	ital or Att rs after de al Diracto ied in by t	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	y - At home, farm, si (Specify)	treet, factory, office		28f. Location (S City or Tow	itreet and Numbern, State)	or Rural Ro	oute Number,		
	To the Hospital or Attand within 24 hours after death To tha Funaral Diractor: completely filled in by the	Medical	one) 2 Medical Exami	sicien: To the best of ner: On the basis of e and manner state	xamination and/or ii	nvestigation, in my o	pinion, death occurr	ed at the time, o	date and place, a	ind due to the	e cause(s)		
	To Nitit	2	29b. Signature and title of certifier	Land	<u></u>	29c. Licens	1010	3	12\3 j	(Month, Day)	, Year)		
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			1 - For State Registrar	;	State of M	aryland		artment of F rtificate of			ental Hy	giene Reg. No.	HILL	39243	
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7	Examir	er	4a. Facility Name (If not institut	_			TITON.	4b. City, Town, o		on of Death		4c.	County of Dea		
	-		LAURELWOOD NU  5. Social Security Number	6. Sex		ge (in yrs. las			KTON If Und	ler 24 Hrs.	3. Date of Bi	rth	CEC		
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9-0	"naturel",	ted	15. Deced	ent's Educa	tion		16a. Dece	dent's Usual Occup	ation			16b. Kir	nd of Business	/Industry	
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Z	should nd Me mark matic	은	Donald Garne  19a. Informant's Name/Relatio				19b. Maili	ng Address (Street		ary Ric		er City or	r Town State	Zin Code)	
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Je,	es 1 and of Health f Item 27 r other tr		20a. Method of Disposition			con	ce of Disp	osition (Name of matory or other place		Da			cation - City or		
im	Pages nent of ent: If it ury or o		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		noval from State			anor Ceme		7 12/2	2/04	Ches	sapeake	City, MD	
Baltimore,	permit. Pages 1 and: Depertment of Health Importent: If Item 27 any Injury or other tr		21. Signature of Funeral Servi	e Licensee			2	2. Name and Addres	ss of Fac	Funer	al Hor				
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68760,	ificate be executed g physician and as the burial-transit	edicai		d						-					
	attending for use as		IF FEMALE: 23b. Was decedent pregnant	230	. If yes, outcome							2	23d. Date of del	livery	
Box	The law requires that the death cent ite has been signed by the attending page 2 should be detached for use	Physician/M	in the past 12 months?		1☐Live birth 4☐Pregnant a			⊒Ectopic pregnancy ⊒ Other <i>(specify)</i>	· 				Month	Day Year	
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	es this	by	Part II. Other significant cond	tions contr	buting to death t	out not resulti	ing in the u	nderlying cause give	en in Par	rt I.		•	P	the cause of death?	
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VII.	Physicien: The I this certificate ha ral director, page	o Be	25. Was case referred to medi examiner?  1 ☐ Yes 2 ▼ No	-	spital: 1 ☐ Inpati	205	3/Outpatie	Othe		ce of Death (					
	g Phys er this eral di	n: To	27. Manner of Death		28a. Date of Inju	ıry 2	Bb. Time o				d. Describe		Other (Specy occurred	city)	
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	114		30. Name and address of person	n who com	pleted cause of	leath (Item 2	h	11		1. 11		121	ilt.	10 7 1621	
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			State of Maryland / Dep	artment of F		and M	-				
			Registrar  1. Decedent's Name (First, Middle, Last)	Timodic or	Doain		2. Date of De	ath	<del>2004</del>	a.Timb 2DdathL	
н	Physicia		DOROTHY GOELLER		Month NOVEME					11:30 A <sup>M</sup>	
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, o	r Location of		NOVERIDE		, 2004 County of De		
	LAGIIIII	<b>~</b> !	4517 Rising Lane	Bowie				Pr	ince (	Georges	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		If Under Hours	h 4:	8. Date of Bir	th	9. B	irthplace (State or Foreign Country)	
	Director		067-14-1085 1□M 2XIF 99 Yrs.	Months Days	Hours	WIII I.	Feb. I	7,190	)5 Nev	v York	
	pu *		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or L	ocation						10d. Inside City Limits	
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	the N	Directo	Maryland   Prince Georges   Bowie	10f. Zip Code				10a Citiz	og. Citizen of What Country?		
	with with	Ö		20715				USA			
	ns 23	Funeral	4517 Rising Lane  11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of H		gin? (Spe	cify Yes or No		4. Race - An	nerican Indian,	
	ritan Lirer	Fun	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ※ ☐ No	If Yes, specify Cuba 1 Yes 2 No	an, Mexicar	i, Puerto F	Rican, etc.)		Black, Wh	nite, etc.	
8	al', o	þ	3√ Widowed 4 □ Divorced If Yes, Give Year or Dates:				Specify: Wh	nite			
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Ž	2 should and Men is marke sumatic	2		ling Address (Street						, Zip Code)	
	and 2 :salth au n 27 is		Dorothy A. Goeller/ Daughter 4517	Rising La	ane Bo	wie,	Maryla	and 2	20715		
e,	一工商量		20a. Method of Disposition 20b. Place of Disposition cametery, cre	amatory or other place	ce)	D	ate	20c. Loc	cation - City o	or Town, State	
Itimore,	Pages nent of int: If it		1 XBurial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)  HillsPC6	ss		1/24	/04	Broo	klyn,	New York	
ಡ	permit. Page Department of Important: If any injury or once.			22. Name and Addre	ss of Facilit	y Rob	ert E.	Evar	ıs Fune	eral Home	
<u> </u>	89 = 89		1 pt I know	16000 Anna	apolis	Roa	d Bowie	e, Ma	ryland	20715	
г			23a. Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	iter the mode of dyin	ng, such as	cardiac or	r respiratory a	rrest,		Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition	40 Caro	lial	114	fari	te	·//	1 clara	
	/Medical Examiner	J.	resulting in death)  Due to (or as a consequence of)	- 0-	010		1		,	2 0	
ı.			Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	Mro	815					Logar	
	nsit	min	cause. Enter Underlying Cause (Disease or injury	Sim						20 year	
,	execting and ital-tra	Examiner	that initiated events c.  Due to (access aconsequence of):							2007	
8760	icate be executed physician and s the burial-transit	dical	d								
9	ng ph as th	Wed	IF FEMALE:								
Вох	ath ce ttendi	an/l	23b. Was decedent pregnant 1	□Ectopic pregnancy	y			2	3d. Date of d	elive <i>r</i> y Day Year	
0	es that the death certific igned by the attending E be detached for use as	Physician/Me	1 Yes No 4 Pregnant at time of death 5	Other (specify)						24,	
٥.	that the sed by detac	Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause giv	en in Part I		23e. Did t	obacco us	se contribute	to the cause of death?	
Records,	The law requires that the death certiff ate has been signed by the attending lage 2 should be detached for use as	d by	Stroke				1 🗆 '	Yes 🏂	No 3□F	Probably 4 Unknown	
CO	w requir been si should	Completed					24a. Was	an	24b. Were a	autopsy findings available	
Re	sician: The law certificate has b irector, page 2 s	dmo						rmed?	death?	completion of cause of	
Vita	an: T tificat tor, p	Be C	25. Was case referred to medical		26. Place	of Death	(Check only of	- 4	1 1 16	55 2 100	
	ysici is cer direc	To B	examiner?  1   Yes   2   No	ent 3 DOA Oth	er: 4 Nu	ırsing Hon	ne 5 Resid	dence 6	☐Other (Sp	ecify)	
0	ding Physician: The In. After this certificate hat funeral director, page		27. Manner of Death 28a. Date of Injury (Month, Day Year) Injury	of 28c. Injur Wor	y at rk?	2	8d. Describe I	now injury	occurred		
<u> </u>	andir sath. or: Af he fu	atic	2 Accident investigation	M 1	Yes 2□	No					
Division of	or Att fter d Diract in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office		2	8f. Location (S City or Tox	Street and Number or Rural Route Number, wn, State)			
	pital o		29a. Certifier Certifying Physician: To the best of my knowledge, dea	th accurred at the ti-	doto on		and due to the	001100(0)		a state of	
	To tha Hospital or Attanding Physician: within 24 hours after death.  To tha Funaral Diractor: After this certifica completely filled in by the funeral director, p.	edical	(Check only one)    Check only one   Che	nvestigation, in my c	pinion, dea	th occurre	ed at the time,	date and	place, and du	ue to the cause(s)	
	Fo the within Fo the compli	Me	29b. Signature and title of certifier	29c. Licens	e number	. ^		29d. Date	signed (Mor	nth, Day, Year)	
)	. , , ,		> K. Datheel mid	D:	264	142	2	11	122	104	
			30. Name and address of person who completed cause of death (Item 23a) (Type	, Print)	1	71	0		1.1	D.~//	
	30 M	٠	Riccel Dakheel m. D. 4000 Mit  31. Date filed (Month, Day, Year)  32. Degistrar's Signature	Chelly	12	Kd.	BOW	161	MD	20/10	
	Sta Registi		31. Date filed (Month, Day, Year)  NOV 2 3 2004  32. egistrar's Signature	book							

State of Maryland / Department of Health and Mental Hygiene State
Registrar AMEND ITEM #10a-f PER FH G83Gertificates of Fleath Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Mary K. Gearhart VOV 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Somerford Place Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖫 F 84 171-18-2502 Director PA 2,1919 Usual Residence of Decedent with the Maryland 10b. County UNION 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28e-f show the Medical Examinant ast be notified at LIN CENT Anne Arundel Annapolis PLAINFIELD 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? -2717 Riva Road 1039 RAHWAY 238 21401 07060 USA Funeral Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "naturel", or Items 11. Marital Status o filed within 72 hours after dal Hygiene.

other than "naturel", or Item Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No þ Specify: 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien-Importent: If item 27 is marked other the eny injury or other treumatic event. 12 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roy T. Blair Kathryn R. Hayo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) William R. Gearhart/Son 1039 Rahway Road, Plainfield, NJ 07060 20b. Place of Disposition (Name of cemetery, crematory or other place) Nov. 23, 20c. Location - City or Town, State 20a. Method of Disposition cometery, cromatory or other place)
St. Mary's Cemetery 1 Burial 2 □Cremation 3 □Removal from State Freeport, PA \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun al Service Licensee Barranco Scris, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 Part Enter the disease shock, or heart failure or complications that caused the de-List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) HLZHEIMERS DEMENTIA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner Cause (Disease or injury attending physician and for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed: certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 X No Division of Vital To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X ther (\$55) \$15 D P 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 □ Yes 2 □ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 | Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) names, D57531 NOY 20, 2004 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Millersville, MD 8601 VCTerans NESO 31. Date filed (Month, Day, Year) **A**gistrar's Signature 2 3 2004

DHMH 17 Rev 1/2001

Registrar

				For State Registrar	State of	f Maryland		artment of H		and Mental Hy	_		
		Physici	an	1. Decedent's Name (First, Middle, La	•			imouto or	Dodin	2. Date of De	Day	Q	3. Tinha of Dodays 6
		/Medic	al	William Hankers  4a. Facility Name (If not institution, given		nher)		4b. City, Town, o	or Location o	Novemb	4c. Count	2004	0.750M
	1	Examin	er	Peninsala Regional		Center		Salisbu		J Bouti		omico	
		Funeral		5. Social Security Number 6. 8	Sex IOXM 2□F	7. Age (In yrs. la		If Under 1 Year Months Days		24 Hrs. 8. Date of Bi Min. (Month, D.	rth		ace (State or Foreign
		Director		267-60-8170 Usual Residence of Decedent	ILAM ZUF	62	Yrs.	,	]]	May 9,		G	
		show		10a. State 10b. County		10c. City	, Town or Lo	cation				1	Od. Inside City Limits
		a Man	ctor	MD Somer:	set	Ed	en						1X Yes 2 ☐ No
		death with tha Maryland ms 23s or 28s-f show	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Coun	try?
		eath v	eral	31996 Flower Hill		Rd.	5 12 1	2182		gin? (Specify Yes or N		S.	no Indian
	(0	r item	Funeral	1 Never Married 2 Married	Armed Fo	rces? 2No	1	f Yes, specify Cub	an, Mexican	, Puerto Rican, etc.)	Bla	ck, White,	etc.
	03	72 hours after death with tha M "naturel", or items 23a or 28a-f idical Examination (Millian	d by	3 Widowed 4 Divorced	If Yes, Giv Year or Da	e		l⊡Yes 2. ⊠Z No	Specify:		Specia	'n Bla	ck
	21215-0036	be filed within 72 hours after tal Hygiene. Id othar than "naturel", or ite event. Itte Medical Exercitie	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)		(Give	lent's Usual Occup kind of work done OO NOT use retire	durina most	t of working	16b. Kind of B	lusiness/Ind	ustry
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1	DQ.	e filec al Hyg otha vent.	BeC	17. Father's Name (First, Middle, Last	)			alstruct.		r's Name <i>(First, Middle</i>			CTOH
2	<u>yla</u> i	2 should be filed withir and Mental Hygiene. Is merkad othar than aumatic event, Tie M	10	William Hankerson						l Mincey			
0	Maryland	and 2 sh ealth and n 27 is m		19a. Informant's Name/Relationship ( Letha Hankerson/v						or or Rural Route Numb			,
60		gas 1 and 2 should be filed within 72 hours after de t of Health and Mental Hygiene. If item 27 is markad other than "naturel", or items or other traumatic event. The Medical Exertive Land		20a. Method of Disposition	viie	20b. PI	ace of Dispo	sition (Name of	1-	Church Rd.,	20c. Location		
1	m 0	Pagas ent of nt: If i		1 ☐ Surial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Special		State		natory or other pla	· +	11/27/2004	Fden	MD	
10	Baltimore,	parmit. Pagas 1 and 2 Department of Health a Important: If item 27 is any injury or other tra ance.		21. Signature of Euneral Service Line	-65%		22	. Name and Addre	ss of Facilit	у	500	עוניי	
26		20529		23a. Part1. Enter the disease, or com						n Funeral H , Salisbury		801	
_				23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on e	ach line			and the second	NEUM			Approximate Interval Between Onset and Death
		Physician /Medical		disease or condition resulting in death)	a. A CU	or as a consequ		SITTIAL	- +	NEUM	DIVIA	-	20 DAYS
		Examiner		Convertible list and dates	b	01 40 4 00110040	01100 017.						
-		sit 9d	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Dua to (	ог аз а солзаци	ansa off.						
(00		be exacuted ician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (	or as a consequ	ence of);					-	
23	8760	cate be exacuted physician and the burial-transit	dical E		d.		,						
K	.89		Medi	IF FEMALE:									
7	30X	The law requiras that the death certificate has bean signed by the attending page 2 should be detached for use as	Physiclan/Me	23b. Was decedent pregnant in the past 12 months?	1□Live b	come of pregnar irth 2 🗆 Fetal	death 3	Ectopic pregnancy	y			te of delive	y Day Year
-	0	that the de ed by the a detached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregn: 9☐Unkno	ant at time of de own	ath 5	Other (specify)					
5	۵.	s that the ned by detac	by Ph	Part II. Other significant conditions	ontributing to de	ath but not resu	Iting in the ur	derlying cause giv	ven in Part I.	23e. Did t	tobacco use conf	tribute to th	e cause of death?
2	rds	w requiras that bean signed t should be det	ed b	ACUTE RE	ENAL	FAIL	NRE			1 🗔	Yes 2 No	3 🗌 Proba	ibly 4 Unknown
	ecc	e law re has be je 2 sho	Completed							24a. Was	an 24b.	Were autop	sy findings available apletion of cause of
	a R	hysiclen: The Iz nis certificate ha I director, page 2								perfo	ormed? 2XNo	death?	2 No
	Vitt	siclen: Th certificate irector, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	npatient 2 🗆 E	D/Outpation	t 3 DOA		of Death (Check only or rsing Home 5 ☐ Resi		/2 /	
	) of	g Phy er this neral d	-	27. Manner of Death		-	28b. Time of Injury	28c. Injur	ry at		how injury occur		
	Sior	endin auth. or: Aft	atio	1 Accident 5 Pending investigatio	n	n, Day Your	Пригу		Yes 2 1	No			
	Division of Vital Records	or Att	Certification;	3 Suicide 6 Could not be determined	289. Place	of Injury - At hor ng, etc. (Specify,	me, farm, stre )	eet, factory, office		28f. Location ( City or To	Street and Numb wn, State)	er or Rural	Route Number,
		pspital hours a ineral y filled		29a. Certifier 1 🔀 Certifying Ph	ysician: To the	best of my know	vledge, death	occurred at the tir	me, date and	d place, and due to the	cause(s) and ma	anner as sta	ited.
		To the Hospital or Attending Physicien: within 24 hours after death.  To the Funeral Diractor: After this certifica completely filled in by the funeral director, g	Medical	one)	and mann	er stated.				th occurred at the time,			
		7 × × ×		Sob. Signature and title or contribution	Yac	lu	, M.	D	4	6962	Novem.	BER	20,2004
		311		30. Name and address of person who	completed cause	e of death (Item ENIN St	23a) (Type, I	REGIOI	NAL	MEDICAL	CEN	TER.	MD 21801
		Sta Registr		31. Date filed (Month, Day Year) NOV 2	2004 <sup>32. Re</sup>	egistrar's Signati	nte /	& Spa	uks				

State of Maryland / Department of Health and Mental Hygiene 2004 39247 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 12:03 PM **Physician** 28, 2004 Hopwood November Victoria /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** Washington 11 W. Baltimore St. Apt. 432 Hagerstown | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | June 7,1923 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Pennsylvania 1 ☐ M 2 □ F Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a. State 10c. City, Town or Location 7 is marked other then "natural", or Items 23e or 28e-f show treumatic event, the Madical Ext. vir et must be notified at 1 ▼Yes 2 No Director Washington Hagerstown MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Apt. 432 11 W. Baltimore St. 21740 U.S.A. Completed by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mentaí Hygiene. Int: If item 27 is markad other then "natural", or Ite 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: White Baltimore, Maryland 21215-0036 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Thomas Henry King Victoria Beaver 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dr. Victoria K. Lyle/Daughter 1503 Dockside Drive, Frederick, MD or other 20a. Method of Disposition
1 □ Burial 2 ☒ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page Department of Importent: If any injury or once. Smithsburg Crematory | 11/30/2004 | Smithsburg, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rest Haven Funeral Chapel SMark 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CONVESTINE UN KNOWN Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner signed by the attending physician and d be detached for use as the burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23d. Date of delivery NA IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) I ☐ Yes 2 PNo 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy performed page 1 Yes 2 No 1 Yes 2 No certificate 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ this ierel Director: After the filled in by the funeral Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification; Injury 1 Natural 5 Pendina NIA NIAM 10 Yes 2 No IA investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 🗌 Suicide 4 T Homicide within 24 hours a To the Funerel [ 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who complained cause of walking Street Community Health Center

LANCA B ASHRE M.D 24 N Walking Street Fairing Practice 04 32. Regist 12005 JOHN MD 21740 31. Date filed (Month State Registrar

Christine Harper 04-07738 DOS

			1 - For State Registrar	State of Maryland	l / Depa <i>Cei</i>	artment of He tificate of D	ealth and M <i>leath</i>	lental Hygien Reg. N	2004	39248		
			1. Decedent's Name (First, Middle, Las	t)	-			2. Date of Death	<sup>ay</sup> 2, 2004	3. Time of Death		
	Physici /Media		Christine		December	0424 ам						
	Examir		4a. Facility Name (If not institution, give	40	4c. County of Death							
			Saint Mary's Ho 5. Social Security Number 6. Se	et hirthday)	Leonardt	OWN If Under 24 Hrs.		t. Mary's				
Н	Funeral Director			7. Age (In yrs. la:	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Year May 16, 19	) Coun	lace (State or Foreign try) vland		
			Usual Residence of Decedent					11ay 10, 1.				
	r 28a-f show	Ļ	10a. State 10b. County	10c. City,	Town or Lo	cation			1	Od. Inside City Limits		
	8a-f	Director	Maryland St. Ma	ary's		Lexingto	on Park			1 ☐ Yes 2 € No		
	with ti		10e. Street and Number			10f. Zip Code			itizen of What Coun			
	ns 23	Funerai	21579 Forest Rur	n Drive 12. Was Decedent Ever in U.S	13 \		20653		nited Sta 14. Race - Americ			
21215-0036	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show alsoa Examilied must be notified at	by	1 ■ Never Married 2 Married 3  Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ■ No If Yes, Give Year or Dates:		Vas Decedent of Hisp f Yes, specify Cuban, □ Yes 2 ☑ No	Mexican, Puerto Specify:	Rican, etc.)	Black, White,	etc.		
2-0	n 72 hours "natural",	Completed	15. Decedent's Ed	ucation	16a. Deced	lent's Usual Occupati kind of work done du	ion	16b. i	16b. Kind of Business/Industry			
21	within 9	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired)	raig most of works	,,,g				
121	Hygier Hygier ther th		17. Father's Name (First, Middle, Last)	2	Sa.	les Clerk	O Mathada Nasa		Retail			
Maryland	2 should be filed withir and Mental Hygiene. Is markad other than aumatic evant, ILE M	Be		(First, Middle, Maide	en Sumame)							
Ž	should od Men marka matic	To	Robert E. Harr	nona Boeh	or Town State Zin	Code)						
<b>≥</b>	nd 2 s lith ar 27 is r trau		Robert Harper / H					Lexington				
ē,	s 1 and 2 should be filed within 72 hr Health and Mental Hygiene. Item 27 Is markad other than "natu othar traumatic evant, Ire Medical		20a. Method of Disposition	20b. Pla	ce of Dispo	sition (Name of natory or other place)	1 0		ocation - City or To			
E O	Page nent o nt: If ry or		1 ■ Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify	Hemoval from State			1	-2004 Leor	nardtown.	Marvland		
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra <u>once</u> .		21. Sign prof Funeral Service Ligen:		22	. Name and Address	of Facility Bri	insfield Fu l, Leonardt	ineral Ho	me, P.A.		
				70					own, iib	Approximate Interval Between		
	Physician		Immediate Cause (Final disease or condition  Multiple in juvies									
	/Medical	resulting in death)  Due to (or as a consequence of).										
	Examiner		Sequentially list conditions.	b								
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	nce of):							
	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conseque	nce of):							
68760,	icate be execul physician and s the burial-trar	dicai E			,							
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P.O. Box	that the death certific ed by the attending p detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 1 Unknown	23c. If yes, outcome of pregnand 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown			23d. Date of delivery Month Day Year					
	requires that the een signed by the nould be detached	by Ph	Part II. Other significant conditions co	ontributing to death but not result	ing in the ur	derlying cause given	in Part I.	23e. Did tobacco	use contribute to th	e cause of death?		
rds	quires n sign uld be							1 ☐ Yes 2	No 3 Prob	ably 4 Unknown		
Records,	e law has b	Completed						24a. Was an autopsy performed?	prior to con death?	osy findings available apletion of cause of		
ta	sician: Th certificate irector, pag	BeC	25. Was case referred to medical examiner?			2	26. Place of Death	Check onl one	, 100	20110		
) t	y si	To	1 X Yes 2 No	Hospital: 1 ☐ Inpatient 2	R/Outpatien	3 □ DOA Other:	4   Nulsing Hot	me 5 🗆 Residence				
Division of Vital	ding After fune	ation;	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	(2/2/6 4	8b. Time of Injury	A 28c. Injury a Work? M 1 □ Ye	es 2 No	Passinger in Viluille a	coidea +	's motor		
Divis	or afte Dire	Medical Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					Playte Number, AND UKS RD. AND County, MD		
	the Hospital in 24 hours tha Funaral ipletely filled	edicai	29a. Certifier 1☐ Certifying Phy (Check only one) 2█ Medical Exam	/sician: To the best of my knowl iner: On the basis of examinatio and manner stated.	edge, death n and/or inv	occurred at the time, estigation, in my opin	, date and place, a nion, death occurre	ed at the time, date an	d place, and due to	the cause(s)		
	To the within 2 To the complete	2	29b. Signature and title of certifier  Zis/Lis/Ul			29c. License r OCME		De	cember 3,	2004		
_			30. Name and address of person who can address of person who can be addressed as a second sec	ompleted cause of death (Item 2	3a) (Type, I	<sup>Print)</sup> 111 Pen	n Street	, Baltimor	e, MD 212	01		
	Sta Registr		31. Date filed (Month, Day, Year)  DEC 0 6 2	32. Registrar's Signatu	re d							

			For State Registra	ır		State of	Maryla	nd / Depa <i>Ce</i>	artment of <i>rtificate o</i>	Health f Death	and M		giene Reg. No.		39249
	Dhysisi		1. Decedent's	Name (First, Midd	lle, Last)							2. Date of Dea Month	ith Day	/ Year	3. Time of Death
	Physici /Medic		R	ose	Mari	e	Ho1me	es				Decembe	r 3	, 2004	6:15 p.m <sup>M</sup>
	Examin	er		ame (If not institution					4b. City, Town	, or Location	of Death		4c.	County of Deat	h
			5. Social Sec	0394 Wate	ervie			s. last birthday)	<del></del>	anics		9. Date of Right		St. Mary	
	Funeral Director			4-4560		M 20 F	. Age (iii yi:	V	Months Day		Min.	8. Date of Birth (Month, Day Aug. 11	, Year)		hplace (State or Foreign untry) cginia
	pu .			nce of Decedent			100 (	City Town or L	antion						10d. Inside City Limits
	shov	5	10a. State 10b. County 10c. City, Town or Location											1 ☐ Yes 2 € No	
	28a-f	Director	Maryla 10e. Street a	nd St. N	lary'	S			Mech 10f. Zip Code	anics	ville		10a Citi	izen of What Co	untru?
	with the or	ā				. D	_								•
	ns 2;	Funeral	11. Marital St	0394 Wate		2. Was Deced	ent Ever in	U.S. 13.	Was Decedent o	.0659 f Hispanic O	rigin? (Spe	cify Yes or No-		ited Sta 14. Race - Ame	ncan Indian,
920	s 1 and 2 should be filed within 72 hours after death with the Maryland Fleath and Mental Hygiene. If the firm 27 is marked other than "natural", or Itame 23a or 28a-1 show other traumatic event. If a Moulcal Exp. liter:	by Fur		r Married 2 Ma		Armed Force 1 Tyes 2 If Yes, Give Year or Dat	No No		If Yes, specify Co 1 ☐ Yes 2 █ N			Rican, etc.)		Black, White	
0-0	natura ical	ted		15. Decede	nt's Educa	ation		16a. Dece	dent's Usual Occ	upation	act of working		16b. Ki	nd of Business/l	Industry
21215-0036	2 should be filed within 7 and Mental Hygiene. is marked other than "r eumatic avent, the Mod	Completed	Elementar	//Secondary (0-12)		College (1-4	lor 5+)	life.	egal Sec	red)		9		T av-	
	filed Hygie other			Vame (First, Middle	, Last)			_	egal sec		/	(First, Middle,	Maiden	Law Sumame)	
Maryland	ild be lental ked c	To Be	J	ack David	Mite	chell				İ	Heler	n Valet	te W	Vard	
ary	should and Men s marke umatic	_		nt's Name/Relation				19b. Maili	ng Address (Stre	et and Numi				171 111 1111	Tip Code)
	as 1 and 2 of Health a itam 27 is r other trai		Micha	ael M. Ho	1mes	/ Hust			4 Waterv	iew D	rive,	Mechan	icsv	ville, M	D 20659
ore	ges 1 If itan or oth		1.0	of Disposition al 2 Cremation	3 □Re	moval from St	ı	Place of Dispo cemetery, cre-	sition (Name of matory or other p	lace)	Da	ate	20c. Lo	cation - City or	Town, State
Ë	Pages ment of t tant: If its jury or o		` 4 □Don	ation 5 Other (	Specify)				Peace Ce		12-8-2		Mech	anicsvi	.11e, MD
Baltimore,	permit. Pages Department of Important: If i eny injury or once.		Edward		sfiel	d. Jr.	M00	052 30	195 Thr	ee Not	tch Rd	l., Mec	hani		1. Hme.,P.A., MD 20659
	L EXE		23a. Part1. I shock,	Enter the disease, or heart failure. Lis	or complicationly	ations that cau	used the de ch line.	ath. Do not en	ter the mode of d	ying, such a	s cardiac or	respiratory arr	est,		Approximate Interval Between
	Physician		Immediate C disease or c	ause (Final ondition	a	11	ine		mcel						Onset and Death
	/Medical Examiner		resulting in o	leath)		Due to (or	as a cons	uence of):	2.1.						
	Ladimino	_	Sequentially	list conditions,	b.	Due to (or	r as a cons	equence of):							
	ted	nine	cause. Ente	g to immediate r Underlying	₹	240 10 (0)	as a const	squerios or).							
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	ntifica ng ph as th		IF FEMALE:						-				-	1	
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 ⊡ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 1 □ Pregnant at time of death 5 □ Other (specify)									23d. Date of delivery  Month Day Year			
Ω.	that ned by deta	by Ph	Part II. Other	significant condi	ions cont	ributing to dea	th but not re	esulting in the u	nderlying cause	given in Part	:1.	23e. Did to	bacco u	se contribute to	the cause of death?
rds	w requires been sign should be	q pe										107	es 2[	□No 3□Pro	obably 4 Unknown
Records,	The law re- te has bee age 2 sho	Completed			·	<del></del>						24a. Was a autops perfor 1 Yes	SV	death?	topsy findings available completion of cause of
Vital	ian: irtifica	BeC	25. Was case	referred to medic	al					26. Plac	e of Death	(Check only or		72,00	
of V	Physician: r this certificantal director,	To	1 🗌 Yes	2 No	Ho			☐ ER/Outpatier	nt 3 DOA	other: 4 \( \text{N}	lursing Hom	e 5 Resid	ence 6	3 □Other (Spec	ify)
סע	ing P		27. Manner o		ing	28a. Date of (Month,	Injury Day Year)	28b. Time o Injury	W	ork?	1	8d. Describe h	ow injur	y occurred	
Sio	tandi death. tor: A	cati	2 Acci	dent inves	tigation I not be	00- 01	6 lations - 64	h fot		Yes 2		9f Location /C		d Muss bas as Ou	- / Courte Africa has
Division	alor Ai after Dirac	Certification:	4 🗌 Hom		mined	building	g, etc. (Spec	cify)	reet, factory, offic	е		City or Town	n, State,	)	ral Route Number,
	To the Hospital or Attanding Physician: The lav within 24 hours after death. ★o tha Funarel Diractor: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier (Check one)	1 ☐ Certify only 2 ☐ Medica	ing Physi I Examine	cian: To the bas er: On the bas and manne	is of examin	nowledge, deat nation and/or in	h occurred at the vestigation, in my	time, date a opinion, de	and place, a	nd due to the c d at the time, d	ause(s) ate and	and manner as place, and due	stated. to the cause(s)
	To th within To the	Me	29b. Signatu	re and title of certif	er					nse number			9d. Date	e signed (Month	, Day, Year)
	0.11		•	01	2	22	N	)	NO	055	75	/	12	-60-0	4
	5 6		30. Name an	d address of perso	n who com	pleted cause	of death (Ite	ет 23а) (Туре,	Print)						*
-	7		Jen	nifer Sci	nmidt	, D.O.	, 234	15 Thre	e Notch	Road,	Cali:	fornia,	Mai	cyland 2	20619
Ž.	Sta Registr		31. Date filed	(Month, Day, Yea	07	32. Rec 2004	gistar's Sig	nature	Angelle						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Physician Month 6:50 P M 20, **THERESA** PAGE HAIRSTON NOV. 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner LAUREL REGIONAL HOSPITAL LAUREL PRINCE GEORGES 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Dey, Year) Birthplace (Stete or Foreign Country) **Funeral** Months 1 ☐ M 2 🖫 F Yrs. JULY 24,1910 Director 94 579-16-0893 VIRGINIA Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic svent, the Medical Examples in the notified at 1▼ Yes 2 No Directo MD. PRINCE GEORGES BELTSVILLE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 11503 ALLVIEW DR. 20705 Funerai U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2**X** No Specify: þ Specify: 3 Widowed 4 □ Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 CUSTOMER SERVICE HOUSEWARE permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic svent space. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ALEXANDER PAGE AMANDA UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM C. RHEUBOTTOM/SON 3108 SOUTH WALDEN ST., SEATTLE, WA. 98144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) CHAMBERS CREMATORY 11-23-2004 RIVERDALE, MD. 21. Signature of Funeral Service Licenses CHAMBERS FUNERÁL HOME & CREMATORIUM, P.A M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician PNEUMONIA** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Il or Attending Physician: The law requires that the death certificate be executed after clearh.

The clear that this certificate has been signed by the attending physician and Director. After this certificate has been signed by the attending shysician and in by the funeral director, page 2 should be detached for use as the burish-transit Due to (or as a consequence of) Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ▼No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, DIABETES MELLITUS 1 ☐ Yes 2 ☐ No 3 Probably 4 NUnknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No **HYPERTENSION** 24a. Was an 1 Yes 2X No 25. Was case referred to medical 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2X No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral D Hospital 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0054547 NOV. 22, 2004 30. Name and address erson who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 7350

VAN DUSEN RD. #350, LAUREL, MD. 20707

CRITTENDEN, M.D.

32. Registrar's Signature

31. Date filed (Month, Day, Year)

NOV 2 4 2004

			1 - For State Registrar	State of	f Marylan	•	artmen rtificat			and M	lental Hyo	giene Reg. No. 2	nL	30251
	Physici		Month							2. Date of Dea Month Novemb				
	/Medi Examir		As Franchis Manual Control of the Co						110 V CARL	4c. County				
	Funeral				7. Age (In yrs.	last birthday)	If Under		If Under	24 Hrs.	8. Date of Birth			
	Funeral Director		578-40-3381 Usual Residence of Decedent	1□ M 2⊠ F	72		Months	Days	Hours	Min.	8. Date of Birtl (Month, Day April 5	, 1932	Washi	lace (State or Foreign try)  ngton, DC
	and and		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10	Od. Inside City Limits
	Mary f sh	ō	Maryland Frederick Frederick									1 X Yes 2 ☐ No		
	28a	rec	10e. Street and Number	IICK		Fred	10f. Zip					10g. Citizen of \	What Coun	trv?
	72 hours after death with the Maryland neturet', or items 23a or 28a-1 show disal Evantrat must be notified at	Funeral Director	1001 Carroll Pa	arkwav			21	701				United	State	96
	death	nera	11. Marital Status	12. Was Dece	dent Ever in U	.S. 13.			spanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)		e - Americ	an Indian,
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933	ours Fet',	d by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Da	ates:		1 🗌 Yes 🔞	Z MŽ NO	Specify:			Specify	~ Whi	te
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121	within ene. than "	mpi	Elementary/Secondary (0-12)	College (1-	-4or 5+)				)					
2	iled v dygie ther t		9 17. Father's Name (First, Middle, La	net)		Home	maker		10 Matha	do Nome	(First, Middle,		Home	
and	ntal hed of	Be.											10)	
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Maryland	d 2 s Ith an 27 is trau	1 8	Dan Lawton / So											
	Health Health tem 27 other to		20a. Method of Disposition	m-In-Law	20b. P	lace of Dispo	sition (Nan	ne of		50 1	Frederic	20c. Location -		
OL.	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Importent: If item 27 is marked other than "neturet", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at ance.		1 ☐ Burial 2 ☑ Cremation 3  4 ☐ Donation 5 ☐ Other (Spe		state	emetery, crer ederick	-	-	· 1 1	Nove				
Baltimore,	permit. Page Department of Importent: If any injury of		21. Sign ture of Fuperal Service Lie		116					24, 2 v s+	uffer E	Frederic	K, Ma	aryland
B	Depa Impo any ir		> Wast	1		16	21 Op	ossu	mtown	ı Pik	te Fred	lerick.	Marv1	and 21702
	· -		23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that ca	aused the deat									Approximate
	Physician		Immediate Cause (Final disease or condition			oithe	135.6	ي م م	tu:	hea	at dis	.o.c		Interval Between Onset and Death
	/Medical		resulting in death)		or as a conseq		-0 (0				0111			_
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	p #	iner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury		to for as a consequence of:									
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P.0.	it the death cer by the attendir tached for use	Jysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkno										
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00	aw requir s been sl 2 should	ojet	Sovere chr	ionic ch	schrud	tion & S	Puln	nary	130	-0 615	24a. Was a			sy findings available
of Vital Records,	The lav	Completed by									autops perform	med?	leath?	pletion of cause of
ita	(0 55	Be C	25. Was case referred to medical		_				26. Place	of Death	(Check only on		L 163	20110
<b>f</b> <	Physicien: this certificatal director,	ToE	examiner? 1 🗌 Yes 2 🖼 🕶	Hospital: 1 🗆 In	patient 2	ER/Outpatien	t 3 🗆 DO	A Othe	r: 4 🗆 Nur	rsing Hor	ne 5 Reside	ence 6 Othe	er (Specify)	
0		.:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date o	f Injury h, <i>Day Year)</i>	28b. Time of Injury	21	Bc. Injury Work			28d. Describe ho			
Sio	endi eath. or: A the fu	cati	2 ☐ Accident investigat				М		es 2□N	No				
Division	I or Attendi after death. Director: A I in by the fu	Certification;	3 Suicide 6 Could not 4 Homicide determine	286. Place	of Injury - At ho g, etc. (Specif	ome, farm, stre	eet, factory	, office		2	28f. Location (St City or Town		er or Rural	Route Number,
	urs al	Ce												
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the laminer: On the barrand mann	sis of examina	wledge, death tion and/or inv	occurred a restigation,	in my op	e, date and inion, deat	d place, a h occurre	and due to the ca ed at the time, d	ause(s) and ma ate and place, a	nner as sta and due to	ited. the cause(s)
	To th within To th	Me	29b. Signature and title of cartifier					License			2	9d. Date signed		Pay, Year)
)			Hart & C.	alou 6	il mi	>	7	D71	155	7		11/20	104	
-	0		30. me and address of person wh		of death (Item	23a) (Type,	Print)	0	~ ~				-	
			Jaract Ciarko				dge	* wel	6 19	100	Frede	rick "	31701	
	Sta Registr	47	31. Date filed (Month, Day, Year)	9 2004 >	gistrar's Signa	ture	6	Son	216					

			Ja .	1 - For State Registrar	State of Marylan		rtment of F		ental Hygier	- CUIII4	39252
_		Physicia /Medic		1. Decedent's Name (First, Middle, Last) Beatrice	Elizabeth	Howe		1	Date of Death Month	22,2004	3. Time of Death
		Examin		4a. Facility Name (If not institution, give s  Calvert Count  5. Social Security Number 6. Sex	y Nursing Ce		-	r Location of Deeth  Frederi  If Under 24 Hrs.   8	ck	4c. County of Death Calver	
		Funeral Director		215-36-3908 1□ Usuel Residence of Decedent	M 21 F 93	Yrs.	Months Days	Hours Min. J	Date of Birth (Month, Day, Yes ULY 3, I		
		e Maryland la-f ehow	ctor	Maryland Calve		ty, Town or Loc Prin	ce Fred		Inside City Limits 1 ☐ Yes 2 ☐ No		
		ath with the 23s or 2	ral Dire	10e. Street and Number 355 Radio Dri			10f. Zip Code 206		Citizen of What Country? USA		
	5-0036	ours after de rai', or items Examiner de	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1	as Decedent of H Yes, specify Cuba □ Yes 2 🗓 No	14. Race - American Indian, Black, White, etc.  Specify: Black			
V	21215-0	nit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland entment of Heatih and Mental Hygiene. ortant: if Item 27 is marked other then "natural", or Items 23a or 28a-f show injury or other treumatic event, the Madical Examinational by notified at a.g	To Be Completed	15. Decedent's Educ (Specify only highest grade	cation completed) College (1-4or 5+)	(Give k	ont's Usual Occup ind of work done O NOT use retired O M e s t i c	. Kind of Business/Industry omeone Else's ome			
TIC	aryland?	should be filed withind Mental Hygiene. I marked other ther umatic event, the	To Be C	17. Father's Name (First, Middle, Last) Thomas	Gre	een		18. Mother's Name (	First, Middle, Maid		
ext	, Man	and 2 sho saith and I n 27 is ma		19a. Informant's Name/Relationship (Typ. Sylvia I. Booth	/Daughter	P.O.	Box 91			y or Town, State, Zip Co rick, MD	
Sol of	Baltimore	Peges 1 ament of He ant: If Item ury or oth		20a. Method of Disposition  1   ☐ Burial 2 □ Cremation 3 □ Re  1 □ Donation 5 □ Other (Specify)	amount from State	tuxent	atory or other plac UMC Ce	m. 11/27	/04 H	Location - City or Town untingtow	n. MD
towe	Bait	permit. Peges Depertment of Important: If I eny injury or one		21. Signature of Funeral Service License  Miliadisc A.	Swell	1 4 P r	Name and Addre 51 Dare ince Fr	ss of Facility Sew s Beach ederick,	ell Fun Rd MD 206	eral Home	
1		Physician /Medical Examiner	يد	23a. Part1. Enter the dis-lase, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Esquantially list conditions, if any, leading to immediate	A	pproximate terval Between nset and Death					
	8760,	rificate be executed g physician and as the burial-transit	dical Examiner	Cause (Disease or injury	C.  Due to (or as a consequence of):  d.						
	.O. Box 68	To the Hospitel or Attending Physician: The law requires that the death certifica within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown		23d. Date of delivery Month Day Year				
	rds, P	w requires that been signed t should be deta	ed by P	Part II. Other significant conditions con	tributing to death but not res		derlying cause giv	en in Part I.	23e. Did tobacc	o use contribute to the c	ause of death? y 4 Unknown
	I Reco	The law recate has been page 2 sho	Completed	- Jin	nontra				24a. Was an autopsy performed?	death?	findings available etion of cause of
	f Vita	hysician: nis certific I director,	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital: 1   Inpatient 2	ER/Outpatient	3☐ DOA Oth	26. Place of Death (er. 4 Phursing Home		6 □Other (Specify)	
	Division of Vital Records, P.O.	ttending Physician: death. stor: After this certific r the funeral director.	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At he	28b. Time of Injury		Yes 2 No	d. Describe how in	jury occurred  and Number or Rural Ri	oute Number
	Div	To the Hospitel or At within 24 hours after or To the Funeral Directompletely filled in by	ai Certif	4 Homicide determined	building, etc. (Specif	(y)			City or Town, Sta	afe)	
_		To the Howithin 24 h	Medicai	(Check only 2 Medicel Examinone)  29b. Signature and title of certifier	er: On the basis of examina and manner stated.	ation and/or inve	29c. Licens	e number	at the time, date a	and place, and due to the Date signed (Month, Day	e cause(s)
	•			30. Name and address of person who cou	mpleted cause of death (Item	n 23a) (Type, P		25475		11123/0	4
		4 Sta	te_	Mukesh N. Mat	hur, M.D.				ce Frede	erick, MD	20678
	100	Registr		NOV 2.5	32. Registrate Signal	ce B.	GORNE	,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		•	ertificate of l		, ,	eg. No	
			Decedent's Name (First, Middle, Last	)				2. Date of Dear	th ZUULS	3. Time of Deeth
ı	Physici /Medic		Karl Noble Hunger	buhler				Novembe	er 21, 2004	3:30 a M
1	Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. County of Death	
			Calvert Memorial	Hospital			Frederic		Calvert	5
	Funeral		5. Social Security Number 6. Se	x 7. Ag ¶M 2□F	e (In yrs. last birthd Yrs	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birth	place (State or Foreign ntry)
	Director		232-52-7601 Usual Residence of Decedent	-	69 Yrs			12/4/19	934	PA
	yland now		10a. State 10b. County		10c. City, Town or	r Location				10d. Inside City Limits
	a-fsh	ctor	MD Calve	ert		Dunk	irk			1X Yes 2 □ No
	ith the	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Cou	ntry?
	ath w	rail	2030 Mc Cracken Dr			2075			USA	
	er de Items	Funerai	11. Marital Status	12. Was Decedent   Armed Forces?	Ever in U.S.	<ol> <li>Was Decedent of Hi If Yes, specify Cuba</li> </ol>	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
36	urs aft	by F	1 ☐ Never Married 2 ▼ Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 ☐ I If Yes, Give Year or Dates:	1953–56	1 ☐ Yes 2X No	Specify:		Specify: Wh	nite
ŏ	4 within 72 hours after death with the Maryland jiene. I then "natural", or tieme 23a or 28a-f show The Medical Evaninat must be notified at		15. Decedent's Edu	cation	16a. De	ecedent's Usual Occupa	ation		16b. Kind of Business/In	
21215-0036	within 7 ene. than "n	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5	lif	ive kind of work done of e. DO NOT use retired	during most of work )	ing		
2	e filed wi I Hygien other th	Con	12		E	levator Med			Elevator (	Company
and	e d stal	Be	17. Father's Name (First, Middle, Last)						Maiden Surname)	
2	s 1 and 2 should be I Health and Mental Item 27 Is marked o other traumatic eve	ဥ	Alfred Hungerbuh		10b 14	ailing Address (Street		Noble	Charles Town Charles Ti	0.4.1
Maryland	id 2 should lith and 27 is m		Bertha Hungerbuhle						; City or Town, State, Zig. $^{\circ}$ , MD $20754$	Code)
<u>6</u>	ss 1 and of Health item 27 other to		20a. Method of Disposition	ST\ MTTE	20b. Place of Di	sposition (Name of			20c. Location - City or To	own, State
E O	00-		1 X Burial 2 ☐ Cremation 3 ☐ F  `4 ☐ Donation 5 ☐ Other (Specify)	Removal from State		crematory or other place orial Garde		4/2004 I	Dunkirk, Mar	cyland
Baltimore,	artr orth		21. Signature of Funeral Service Licens	9 ~		22. Name and Addres	o of Engille		ood Funeral	
m	Depa Depa Impo any iv		1 C. W	on		PO Box 430				nome, r.A.
П			23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	ications that caused ne cause on each lir	the death. Do not	enter the mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Cavo	nam F	tytery .	diseas	0		Onset and Death
P	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):		7			
	LAdimirei	_	Sequentially list conditions,	Conc	consequence of):	Heart	failu	me		
	ted nsit	nine	Sequentially list conditions, Tany, leading to immodulate cause. Enter Underlying Cause (Disease or injury	Charma			2 1	۷.	2222	
	al-trai	Examiner	that initiated events resulting in death) Last	Due to (or as	a consequence of):	ructive t	ulmon	my a.	sease	
09/89	rificate be executed ng physician and as the burial-transit			Plew	ral E	ructive F ffussion	n Ria	ht sic	de	
	tificat ng phy as th	Medicai								
Box	ndii use	an/N	23b. Was decedent pregnant	3c. If yes, outcome		3 DEctopic pregnancy			23d. Date of delive	
	0 D	Physician/	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at 9□Unknown		5 Other (specify)			Month	Day Year
0.	that the de led by the detached		Part II. Other significant conditions con	stributing to death by	ut not reculting in th	a underhing equal que	o is Post I	22a Did tah	pacco use contribute to the	no aguno of dooth?
Vital Records,	98	d by							es 2 No 3 Prob	
Ö	w require been significant	etec	hyperlipiden Chronic	2001	3 14 Oc. 11	`				
Ř	9 4 9	Completed	Chronic	omai	in sugo	icience	1	24a. Was ar autops perforn	y prior to co	psy findings available mpletion of cause of
co.	ician: Th certificate ector, pag	e Co	25. Was case referred to medical				00 81	1 ☐ Yes 2	2 No 1 ☐ Yes	2 No
	Physician: this certific ral director,	0 8	examiner?	lospital: 1 Compatie	nt 2 ☐ ER/Outpa	tient 3 DOA Othe	26. Place of Death		e) ince 6 □Other (Specif	iv)
101	g Phy er thi	$\vdash$	27. Manner of Death	28a. Date of Injur (Month, Day		e of 28c. Injury	4		w injury occurred	y)
0	Attending r death. ector: After by the fune	atio	1 □ Natural 5 □ Pending 2 □ Accident investigation	(Month, Da)	/ Year) Injur		es 2 □No			
Division	I or Atten after deat Director: in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju-	ury - At home, farm,	street, factory, office		28f. Location (Sti City or Town	reet and Number or Rura n. State)	I Route Number,
	lospital or hours afte uneral Dir ily filled in									
	the Hospital hin 24 hours a the Funeral C mpletely filled	edicai	(Check only 2 Medical Exami	<b>ner:</b> On the basis of	examination and/or	eath occurred at the tim investigation, in my op	e, date and place, inion, death occurr	and due to the ca ed at the time, da	ause(s) and manner as state and place, and due to	tated. the cause(s)
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Med	one) 29b. Signature and title of certifier	and manner sta	ited.	29c. License	number	29	9d. Date signed (Month,	Day, Year)
	F ₹ F 8		06 1	& L	•	D45	_		11/22/04	1
			30. Name an odress of person od co	ple d cause of d	eath (Item 23a) (Tvr		UTA		111220	1
	15		Parul Jani, M.D.	V.		l, Prince F	rederick.	MD 200	678	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	Signature					

			1 - For State Registrar	State	of Marylai		artmen <i>rtificate</i>			and Mo		giene Reg. No.		04	392	54
	Physici	an	Decedent's Name (First, Middle,)	_ast)							2. Date of Dea Month	ath Day		Year	3. Time of	
	/Medic	cal .	Alma  4a. Facility Name (If not institution, of	ive street and ni		race		offm Town or	an Location of		NOVEMB!	1		2004 of Death	0116	М
	Examin	ier	MEMORIAL HOSPIT				CUMB			or o outr			LEGA			
	Funeral		5. Social Security Number 6	Sex 1□M 2ÅF	7. Age (In yrs	. last birthday)				Min	8. Date of Birt (Month, Day	h v. Year)	1101		lace (State or	Foreign
	Director		220-10-7868 Usual Residence of Decedent	1 M 2 M F	82	Yrs.			1,00.0		08/19/	1922		Mary	Tand	
land	Mo to		10a. State 10b. County		10c. C	ity, Town or Lo	ocation							1	0d. Inside Cit	y Limits
Man	a-f sh	ctor	MD Alleg	any		Flints	tone								1 ☐ Yes	2 (₹No
ith th	or 28	Director	10e. Street and Number		1 1		10f. Zip	Code	04 5 0 (	0		-		What Cour	ntry?	
eath w	18 238 must	Funerai	25108 Pratt S		edent Ever in U	18 13	Was Deced	lent of Hi	21530		cify Ves or No-	US		e - Americ	an Indian	
after d	or itan	Fun	1 Never Married 2 Married	Amed F	orces? 2∭No					, Puerto F	cify Yes or No- Rican, etc.)		Blac	ck, White,		
ours a	iraf, c	d by	3 ₩ Widowed 4 Divorced	If Yes, G Year or I	ive Dates:		1□ Yes	2KJ No	Specify:				Specify	" Wh	ite	
n 72 h	"natu	iete	15. Decedent's (Specify only highest	Education grade completed)	1	(Give	dent's Usua kind of wor DO NOT us	k done c	durina most	t of workin	g	16b. Ki	nd of B	usiness/Ind	dustry	
withi	r than	Completed	Elementary/Secondary (0-12)	College (	1-4or 5+)		lousek		,				Nur	sing	Home	
	and Menial Hygiene. Is markad other than "natural", or Itams 23a or 28a-f show aumatic avant, the Medical Evanther must be notified at	Be C	17. Father's Name (First, Middle, La		М					r's Name hel	(First, Middle,	Maiden trud		ne) Shanh	01+2	
y and the	Ment narkad natic a	2	Ralph	(NMN)	- IT	oore -										
d 2 st	th and		19a. Informant's Name/Relationship Charles Hoffman				-				Route Numbe			State, Zip 21557	_	
s 1 and	f Heal itam 2 other		20a. Method of Disposition			Place of Dispo cemetery, cre	sition (Nan	ne of	1		ate			City or To		
Pages	nent o int: ff iry or		1.X Burial 2 ☐ Cremation 3  `4 ☐ Donation 5 ☐ Other (Spe		State	nset Me	-			1/29/	2004	Cu	mbe	rland	l, MD	
permit.	Department of Health and Mental Hygiene. Important: if items 23a or 28a-f show Important: if item 27 is marked other than "naturaf", or items 23a or 28a-f show any injury or other traumatic avant, the Medical Evandment must be incitibed at once.		21. Signature of Funeral Service Lic	O. A.	Λ	2;					ms Fam , Cumb				Home, 21502	P.A.
	řa.		23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that ly one cause on	aus I the dea each line.	th. Do not en	er the mod	e of dying	g, such as	cardiac or	respiratory ar	rest,			Approximate Interval Betw	reen
	ysician		Immediate Cause (Final disease or condition resulting in death)	aCarc	inoma 1	ung								_6	Onset and D month	
	Medical kaminer		rosulting in doubly	Due to	(or as a conse	quence of):										
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events	b. — Due to	(or as a conse	quence of):								-		
ecuted	physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	c										31		
be ex	ician a burial-	al Ex	resulting in death) cast	Due to	(or as a conse	quence of):										
ficate	physics the	edical		d											-	
Centii	attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant		tcome of pregn		7					2	3d. Dat	te of delive	iry	
death	he atte ed for	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No		birth 2 ☐ Fet nant at time of nown		Ectopic pro Other (sp						Mo	nth	Day Y	ear
hat the	signed by the a		9 Unknown  Part II. Other significant conditions			sulting in the u	ndork (ing. o		on in Port I		23a Did to	hacca III	sa cont	ributa ta th	e cause of de	ath?
Lires t	signe Id be o	d by	arti, other significant condition.	s contributing to c	ibatii batiiotiio	summy in the c	nderlying or	auso give	en in Faiti,		127	,			abiy 4 ⊟Ui	
w req	s been si should	mpieted									24a. Was	an	24b. \	Were autor	psy findings a	vailable
The la	certificate has rector, page 2	Сошр									autop perfor	med2 2 No	ŗ	prior to condeath?	npletion of ca	use of
ian:	ortifica ctor, p	Bec	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o			103	20140	
hysic	this ce al dire	P	1 ☐ Yes 2 ☐ No	,		ER/Outpatier	_		4 🗀 14 0		e 5 ☐ Resid				<i>'</i> )	
ding	h. After funera	tion:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigat		of Injury oth, Day Year)	28b. Time o Injury	т 2: М	Bc. Injury Work	rat ⊲? Yes 2.⊟ñ		8d. Describe h	ow injury	occurr	ed		
Attan	ar death. <b>actor:</b> After this certificate has by the funeral director, page 2	ifica	3 Suicide 6 Could not	be 28e. Place	e of Injury - At h	iome, farm, sti					8f. Location (S	treet and	d Numb	er or Rura	l Route Numb	er,
2 2	al Dire	Certification:	4   Homicide	build	ling, etc. (Speci						City or Tow					
o the Hospital or Attanding Physician: The law requires that the death certificate be executed	within 24 hours after death.  To the Funaral Diractor: After completely filled in by the funer.	Medical	29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the aminer: On the t and mar	e best of my kn pasis of examin nger stated.	owledge, deat ation and/or in	h occurred a vestigation,	at the tim in my op	ne, date and pinion, deat	d place, ar th occurre	nd due to the d d at the time, d	ause(s) date and	and ma place, a	nner as st and due to	ated. the cause(s)	
To th	To th comp	Me	29b. Signature and title of certifier	7			29c	License	number					(Month, l	Day, Year)	
	4			4	That	~~~	D:	3328	0			Nov	2	9, 2	004	
7	13		30. Name and address of person wh					/ A NT I	MD	21500	)					
	Sta	ite	SUNIL GUPTA, M.D. 31. Date filed (Month, Day, Year)		ENT AVE Registrar's Sign		UMBERI	LAND		Z13U2	<u>′</u>			-		
	Registr		NOV 9 9 20	104 /3	S. C. Spander	food	185000	and the state of								

			For State Registrar		State o	f Marylan	-		t of H	ealth a		-	gienę	2001		30250	···•
	Physici /Medio	al	1. Decedent's Name (Fig. 1) LOVAL 4a. Facility Name (Fig. 2)	Hugh	25	nhari	001			Location o	1	2. Date of De Month VOVLIND	er Z		54	3. Time of Death 2 2BA M	1
	Funeral	er	5. Social Security Number 217-28-2312	y 1 M	anylan	7. Age (In yrs.	d Um last birthday) Yrs.		E	If Under a	ore 24 Hrs. 8 Min.	B. Date of Bir (Month, Da	th ly, Year)	lltimore	City Birthplac	e (State or Foreign	חק
	Director	٦.	Usual Residence of Dec 10a. State 10	cedent b. County		10c. Cit	y, Town or Lo	cation				31-Mar-	1930	7000	10d	Incide City Limits	
	with the M 3a or 28e-f	Funeral Director	Maryland  10e. Street and Number	Allega r 223 Brac		Frost    ad	burg	10f. Zip					10g. Citi:	zen of What	Country		_
900	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or Items 23a or 28e-f show avent, I're Medical Eranin ar must be rediffed at	þ	11. Marital Status 1 Never Married 3 Widowed 4	2 <b>X</b> Married	12. Was Dece Armed Fo 1 2 Yes If Yes, Gin Year or D	2 No		Vas Deced	lent of Hi	ispanic Orig n, Mexican Specify:	gin? (Spec , Puerto Ri	ify Yes or No	1	14. Race - Ar Black, W	hite, etc		
21215-0036	he filed within 72 ha al Hygiene Jother than "natu vent, the Medical	Completed	(Specify of Elementary/Secondary 12	`	de completed) College (1	-4or 5+)	16a. Deced (Give life. I	lent's Usua kind of wor DO NOT us	al Occupa rk done d se retired	during most			trucki	nd of Busines		stry	
Maryland	should be fill nd Mental Hy i marked oth umetic even	To Be	17. Father's Name (Firs Charles Hug								r's Name ( eth Sa	First, Middle, I <b>gal</b>	Maiden	Sumame)			
	1 and 2 sho Health and I em 27 Is me		19a. Informant's Name Lois Hughes	/Relationship (7	турв, Print) Wife		19b. Mailir 223 Bro	g Address Iddock	(Street,a Road	and Numbe	r or Rural . Frostb	Route Numbe	er, City or	Town, State	, <i>Zip Ci</i> d	ode) 21532-	
Baltimore,	Pages nent of ant: If it ury or c		20a. Method of Disposit 1 ☑ Burial 2 ☐ Ci 1 4 ☐ Donation 5 ☐	remation 3 🗆 Other (Specify	)	State	lace of Dispo emetery, cren ourg Mem	orial Pa	ther place I <b>rk</b>	-27-90-		te c-2004		urg		n, State yland	
Bal	permit. Departi Import any inj		21. Signature of Funera	bu K	Kle	est	Du	rst Fun	eral H		57 Fros	t Ave., f		urg, MD	215	32	
3760,	Live be executed / Medical Examiner   Published   Publ	dical Examiner	23a. Party Enter the dispose, or heart fa limited asse or condition resulting in death)  Sequentially list condition and the cause. Enter Underlying Cause (Disease or injurthat initiated events resulting in death) Last	ilure. List only all ons, diate	b. Due to Due to C. IS	for as a consequence of the cons	uence of):  uence of):  o Hu	ach act	llat yca Dis	ion rdia ease	cardiac or	respiratory a	rrest,		lr.	pproximate terval Between nset and Death	
P.O. Box 68	the death certif y the attending iched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pre in the past 12 mor 1  Yes 2 No 9  Unknown	nths?	1 Live b	come of pregna irth 2 ☐ Feta ant at time of d	Ideath 3□	Ectopic pre Other (spe					2	3d. Date of o	lelivery Da	ay Year	
	The law requires that the de ite has been signed by the bage 2 should be detached	by	Part II. Other significar	nt conditions c	ontributing to de	eath but not resi	ulting in the u	nderlying ca	ause give	en in Part I.			obacco us		to the	cause of death?	١
Vital Records,	(0	e Completed	25. Was case referred	to madical						00 Disco			rmed? 21X No	24b. Were prior to death	comp	findings available letion of cause of	9
of	Phys r this ral dii	ToB	examiner? 1 Yes 2 No 27. Manper of Death	to madical	Hospital: 1 28a. Date		ER/Outpatien			er: 4 🗆 Nur	sing Home	Check only of 5 ☐ Resided. Describe I	dence 6		ecify)		
Division	ten leat tor: the	Certification;	2 Accident	Pending investigation Could not be determined	(Moni	th, Day Year) of Injury - At ho ng, etc. (Specify	Injury ome, farm, stro	М		(? Yes 2□N	10		Street and		Rural A	oute Number,	
J	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical Ce	29a. Certifier 1X (Check only 2 one)	Certifying Ph Medical Exam	iner: On the b	best of my kno asis of examina ner stated.	wledge, death	occurred a	at the tim in my op	e, date and pinion, deat	d place, an h occurred	d due to the at the time,	cause(s) a	and manner place, and d	as state	ed. e cause(s)	
<b>)</b>	To the within 7	Med	29b. Signature and title	of certifier	M M	_		29c	. License	number			29d. Date	signed (Mo.	nth, Da	y, Year)	
(	5 n iS		30. Name and address	of person who	8.0		23a) (Type,	Print)	1. 1	10. 4.	. 01	can t	R	2	- /	MN	
	Sta Registr	te ar	31. Date filed (Month, C		32. R	egistrar's Signa	ture	Spar	Ks/	n een	ا د ملا	reel		a 1+, v	nor	y, Year) 2004 e, MD	

	•	Í	1 - For State Registrar	State of Mary	-	artment of H tificate of L			iene 19. No. 200	14 39256
	Physici /Medio		1. Decedenl's Name (First, Middle, Last) Waneta Ca	vol	H	lawkins		2. Date of Deat Month Decembe	Day Ye	3. Time of Death OSISPM
	Examir		4a. Facility Name (If not institution, give s  The Johns Itopic  5. Social Security Number 6. Sex	ins Itospita	el n yrs. last birthday)	4b. City, Town, or Bath				Peath  A  Birthplace (State or Foreign
	Funeral Director			M 2□XF 61		Months Days	Hours Min.	8. Date of Birth Month, Bay NOV 20	, <sup>°</sup> 1943	Cours
	e Marylan e-f show	ctor	MD 10a. State Allegan		oc. City, Town or Lo Pinto					10d. Inside City Limits 1 ☐ Yes 2 € No
	th with th	rai Director	P.O. Box 0126	71		10f. Zip Code	21556	1	og. Citizen of Wha	
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 ahow any injury or other traumatic avant. I'm Medical Exam are must be incitified an once.	d by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1	Was Decedent of Hi f Yes, specify Cubar I  Yes 2 No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		American Indian, Vhite, etc. White
21215-0036	d within 72 h giene. er then "netu	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12		(Give	tent's Usual Occupa kind of work done d DO NOT use retired, maker	uring most of wor	king	own home	
Maryland	should be filed within and Mental Hygiene.  I marked other than umatic avant, the Mental avant, the Mental avant.	To Be (	17. Father's Name (First, Middle, Last) Clarence Wilbur	Shook			Evelyn	ne (First, Middle, M Davis SI	nook	
	and 2 sho ealth and n 27 is m		19a. Informant's Name/Relationship (Type Troy Hawkins	son			nd Number or Ru tinsburg		City or Town, Stai enson	ve. <sup>Zip Code)</sup> Va 22656
Baltimore,	Pages 1 ment of He ant: If itan ury or oth		20a. Method of Disposition  1 Surial 2 Cremation 3 R.  4 Donation 5 Other (Specify)	1	Place of Dispo cemetery, cren Biertown Co	natory or other place	9)	the second second	Rawlings	7.00
Balt	permit. Departr Imports any inje		21. Signature of Funeral Service License	) Syll	· L 22	Name and Address Scarpell 108 Virg			and, MD 21	1502
	Pnysician /Medical		23a. Part 1. Enter the disease, or complies shock, of heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	weart fai		, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
8760,	cate be executed physician and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	ary arte	J	thy ase			1 month
.O. Box 6	death certif e attending ed for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 D Yo 9 ☐ Unknown	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
<u> </u>	The law requires that the ate has been signed by the bage 2 should be detache	by	Part II. Other significant conditions con	tributing to death but n	ot resulting in the u	nderlying cause give	n in Part I.		_	e to the cause of death?  Probably 4 Unknown
Vital Records,		Completed						24a. Was ar autops perform 1 Tes 2	prior death	e autopsy findings available to completion of cause of n? Yes 2 □ No
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:	• E7 50/0 · · · ·	Othe	r.	th (Check only one		
Division of	To the Hospitel or Attanding Physicien: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director.	ation: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	lospital: 1 Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatien 28b. Time of Injury	28c. Injury Work	4   Iduising I	28d. Describe ho	nce 6 Other (5 w injury occurred	Specify)
Divis	itel or Atta	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (S	At home, farm, str Specify)	eet, factory, office		28f. Location (Str City or Town		r Rural Route Number,
	To the Hospitel within 24 hours a To the Funerel Completely filled	edicai	29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Examination	sician: To the best of m ner: On the basis of exa and manner stated	amination and/or inv	occurred at the tim restigation, in my op	e, date and place inion, death occu	, and due to the ca rred at the time, da	use(s) and manne ite and place, and	r as stated. due to the cause(s)
)	To the within 2 To the complet	Σ	29b. Signature and title of certifier	) Mat		29c. License		1	od. Date signed (M	
	9	1	30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type,	Print)	000	P		1,2009
Δ.			SUSANNA L A 31. Date filed (Month, Day, Year)	MTSEN 32. Registrar's	600 No	orth Wolfe	Street	Balti	more, Me	4,2004 cryland 21209
	Sta Registi		nra 1 0 200	. W	***	lon V				-

State of Maryland / Department of Health and Mental Hygiene For Stata Registre Certificate of Death <del>0 N L</del> 2. Date of Death a Time of Dealn Decedent's Name (First, Middle, Last) Dec 4, 2004 Year **Physician** 10:50am<sup>™</sup> Hovle Lee /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Cumberland Memorial Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jun 13, 1926 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min N 2□F Director 216-22-7408 Usual Residence of Decedent 78 the Maryland 10c, City, Town or Location 10a State 10h County 10d. Inside City Limits or 28e-f ehow other treumatic event, the Medical Examinar must be notified at Allegany Cumberland MD 1 ¥Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA or Items 23a 21502 219 Utah Avenue by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No

Yes, Give
Year or Dates:

WWII Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian permit. Pages 1 and 2 should be filed within 72 hours atter c Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "netural; or Item eny injury or other treumatic event, the Medical Examina Black, White, etc. 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify white 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City 12 Fireman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stella Kiem Hoyle Charles P. Hoyle ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 529 Clear Ridge Road Union Bridge MD 21791 19a. Informant's Name/Relationship (Type, Print) 529 Clear Ridge Road Robert Hoyle son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Scarpelli Funeral Home, P.A. 12/4/2004 MD Cresaptown ^ 4 □Donation 5 □Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, P.A 21. Signature of Funeral Service Licensee 108 Virginia Avenue; Cumberland, MD 21502 mus Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or year failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Calise (Final disease or condition resulting in death) Physician Respiratory Failure 4-6 hrs /Medical Due to (or as a consequence of): Examiner Pneumothorax 4-6 hrs Sequentially list conditions, if any, leading to immediate cause. Enter Under the Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine use as the burial-transit certificate be executed Carcinoma of the lung with brain metastasis attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Brain stem tumor 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \subseteq \text{Yes} \quad 2 \subseteq \text{No} \) 2 No 1 Yes of or Attending Physicien: after death. Director: After this certification 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: Hospital: ၉ 1 Tyes 2 No 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) tuneral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) tilled in by 4 Homicide To the Hospitel within 24 hours a To the Funerel I 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D26471 12-6-2004 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johnson Heights Medical Bld Cumberland MD 21502 Kheder Ashker M.D. 32. Registrar's Signature State DEC 1 0 2004 Registrar

Vaughn C. Jolley 04 - 7316AKG

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death U4 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** AUGHN 13, 2004 4c. County of Death 2004 /Medical November 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Wicomico Peninsula Regional Medical Center Salisbury
If Under 1 Year I ff Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1**X**M 2□F 219-60-0780 Usual Residence of Decedent Yrs. Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28e-f show injury or other traumatic event, the Madical Examinar must be notified at 1 Yes 2 No Directo MD HARATOWN comico 10e. Street and Number 10g. Citizen of What Country? 25 229 2186 OPERY USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Ite 1 ☐ Yes 2 No If Yes, Give Year or Dates: Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MACHINERY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, PARKER 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RD 4564 JOHN OUIS YARKER-STEPFATHER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) SHARPTOWN MD CEM 11-20-04 21. Signature of Fu ral Service Licensee 22. Name and Address of Facility BENNIE SMITH FIH Bny ST. SALISBURY, MD. 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Approximate Interval Between Immediate Cause (Rinal disease or condition resulting in death) Onset and Death Cardiovascular Disease Atherosclerotic **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit and Due to (or as a consequence of) Records, P.O. Box 68760 attending physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 3 🔲 Probably 4 <del>⊊</del>Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Yes 2 No 1 Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1

Yes 2□No P 1 Inpatient ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27, Manner of Death

1 Natural
2 Accident 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

Carol H. Allan MD 31. Date filed (Month, Day, Year) NOV 2 3 2004

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Penn Street, Baltimore, Maryland 21201

November 14, 2004

O.C.M.E.

Please Type of	or Print in Black Indelible Ink.	Ensure All Copies Are Legible.

			1 - For State Registrar	State of Mar		partment of H ertificate of L		ental Hygier Reg. 1	Z 11114	39259
	Disconici		1. Decedent's Name (First, Middle, La	st)			2	. Date of Death Month	Day Year	3. Time of Death
	Physici /Medio		WILLIAM F	JOSENHANS	S, JR.		1	LOVEMBE	R 18, 2001	1540 p M
	Examir		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or	Location of Death		4c. County of Dear	th
			MANOKINI	JANOR		PRINC	ESS ANN	15	SOME	RSET
П	Funeral			M 2FTF	n yrs. last birthd Yrs	Months Days	If Under 24 Hrs. 8 Hours Min.	(Month, Day, Ye		thplace (State or Foreign buntry)
	Director		213-30-1265 Usual Residence of Decedent	74	113		A	ug. 4, 1	930 Mai	cyland
	ehow		10a. State 10b. County	1	Oc. City, Town o	r Location				10d. Inside City Limits
	Mary	ē	MD. Somers	act	Dri	ncess Anne				1 □Yes 2 →No
	r 28s	Director	10e. Street and Number	500		10f. Zip Code		10g.	Citizen of What Co	ountry?
	h witi	<u>=</u>	13669 Crows Foot	Lane		21853			U.S.	
	deet	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 1	Was Decedent of Hi     If Yes, specify Cuba	spanic Origin? (Speci	fy Yes or No-	14. Race - Ame Black, Whit	
21215-0036	s 1 and 2 should be filed within 72 hours efter deeth with the Maryland Heelth and Mentel Hygiene. Item 27 is marked other than "netural", or Iteme 23a or 28a-1 ehow other traumatic event, the Medical Examinar must be notified as	ρ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 Yes 2 No	Specify:	oan, 610.,	Specify:	nite
9	2 ho	Completed	15. Decedent's E		16a. De	cedent's Usual Occupa	ation	16b.	. Kind of Business/	
215	within 7 ene. than "r	ed	(Specify only highest grant   (Specify only highest grant   (9-12)	College (1-4or 5+)	lif	ive kind of work done d e. DO NOT use retired,	) )			
	filed withi Hygiene. other than	60	12	1	R	eal Estate			eal Estat	e Sales
p	tel Hy d oth	Be (	17. Father's Name (First, Middle, Last	)			18. Mother's Name (	First, Middle, Maid	len Sumame)	
Maryland	2 should be and Mentel is marked o	은	William F. Jos				Ora Du			
Jar	2 sh and le m		19a. Informant's Name/Relationship (			ailing Address (Street a				,,
	s 1 and 3 if Heelth Item 27 other tra		Dorothy Josenhans  20a. Method of Disposition	·		69 Crows Fo sposition (Name of	oot Lane,		Anne, Mo	
Baltimore,	0 = 5		1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, c	crematory or other place	9)			
높	permit Pa Departmen Important: erry Injury		<ul> <li>4 □Donation 5 □ Other (Special</li> <li>21. Signature of Funeral Service Lice</li> </ul>	-	Salisb	iry Cremato 22. Name and Addres		-04 Sa	lisbury,	Md.
Ba	Departm Departm Importa erry Iriju		21. Structure of Pullerar Service Lice	/ MOO	295		•	Prince	acc Anno	Md. 21853
			23a Pert 1. Enter the disease, or com	plications that caused the					oo Allie,	Approximate
			shock, or heart failure. List only Immediate Cause (Final	one cause n each line.	CI	~ ^ ^	Dem			Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a. Due to (or as a c	D Telgi	- Some	den	entra		5 ym
н	Examiner			200 10 (0. 03 0	orisoquarios pi).					
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a c	onsequence of):					
	cuted nd ransit	Examiner	that initiated events	C						
ó,	e exe	EX	resulting in death) Last	Due to (or as a c	onsequence of):					
68760,	icate be executed physicien end s the burial-transit	edical		d						
		We.	IF FEMALE:	23c. If yes, outcome of p	orogo a cou					
Вох	eeth certifi ettending for use es	la La	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of deli Month	very Day Year
	at the de by the oteched	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	e or dealit	5 🗆 Other (specify)				
P.0	The law requires that the deeth certiste hes been signed by the ettending agge 2 should be deteched for use		Part II. Other significant conditions	contributing to death but n	ot resulting in the	e underlying cause give	n in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
of Vital Records,	ures n sign	d by	Viabetes Well	tus Type	II: Esq.	enterel Hy	perference	1 ☐ Yes	2 <b>⊠</b> No 3□Pro	obably 4 🗍 Unknown
Ö	w requires been si	Completed	Paglin and I	) · mani (	provi	en arter	Dine	24a. Was an	24b. Were au	topsy findings available
æ	len: The law rtificete hes b ttor, page 2 s	Ë	()/	D'	2 = 0		1	autopsy performed?	death?	completion of cause of
ta		0	25. Was case referred to medical		-		26. Place of Death (0	1 Yes 2 1	VO ILLITES	2 🗷 No
<u>&gt;</u>	ysicie is cert direct	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient	2 ER/Outpa	tient 3 DOA Othe			6 ☐Other (Spec	eifv)
	Jing Ph After th funeral		27. Manner of Death	28a. Date of Injury (Month, Day Yo	28b. Time	of 28c. Injury Work		d. Describe how in		
Ö	anding ath. or: After	atle	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	n	,		es 2 □ No			
Division	tef or Attending Physician: s efter death. el Director: After this certifice ed in by the funeral director.	Certification;	3 ☐ Suicide 6 ☐ Could not be determined			street, factory, office	28f	Location (Street City or Town, Sta	and Number or Ru	ral Route Number,
	rs eff									<u></u>
	To the Hospitel or a within 24 hours effer or the Funerel Direction completely filled in b	edical	29a. Certifier 1 Certifying Pl (Check only 2 Medical Example)	sysicien: To the best of m niner: On the basis of ex and manner stated	amination and/or	eath occurred at the time investigation, in my op	e, date and place, and inion, death occurred	due to the cause at the time, date a	(s) and manner as ind place, and due	stated. to the cause(s)
	To the I within 2. To the I complet	Me	29b. Signature and title of certifier	7 00 1	, 1	29c. License	number	29d. C	Date signed (Month	i, Day, Year)
		Ŵ.	Treasur 1	a Beli	sao h	-D. V 2	9505	11	1-19	2004
			30. Name and a sess of person who							
			GREGORIO M.			302 CHINA	BERRY DA	., SALIS	BURY, MI	21801
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's	Signature				,	
F1:			NOV Z 3	2004 Ken	es K	greete				
UH	MH 17 Rev 1/2	JUI								

State of Maryland / Department of Health and Mental Hygien 39260 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day **Physician** Lloyd Clarence Jolliff 21 2004 Nov 1:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Charlotte Hall Veterans Home Charlotte Hall St. Mary's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Funeral 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1□M 2□F 491 18 7029 Director 85 June 23 1919 Missouri Usual Residence of Decedent the Maryland 10a State 10c. City. Town or Location 10b. County 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Nedical Examinar Investion in Additional Investions to mainted at Maryland Calvert 1 ☐ Yes 2 ☑ No Port Republic Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3755 Crane Road 20676 United States death y Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after of and Mental Hygiene.
Is marked other than "natural", or iter 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify.white 2 If Yes, Give Year or Dates: 42–45 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 production planner ship building 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William R. Jolliff Ida M. Nichols 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n any injury or other traun Mara Lee Jolliff - wife 3755 Crane Road Port Republic Maryland 20676 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🙀 Burial 2 □ Cremation 3 🖳 Removal from State Jackson Memorial Park 27 2004 \*4 Donation 5 Dother (Specify) Pascagoula Missouri 22. Name and Address of Facility Rausch Funeral Home PA 21. Signature of Funeral Service Licensee M00542 4405 Broomes Is. rd. Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Renal Chronic foulure **Physician** /Medical Due to (or as a consequence of) Examiner oronord Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit oscolor (Acident 5 nultiple Cerebral certificate be executed Due to (or as a consequence of) P.O. Box 68760 Physician/Medical d IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 212 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Injury at Work? al or Attanding P s after death. I Director: After 1-■Natural 5 Pending 1 Yes 2 No investigation М 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral ( 29a. Certifier TC Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 75092 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 8 04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR Parul 5.1 mi mo 110 Hospital Road Suitet 205 Prince Frederick mo 300078 31. Date filed (Month, Day, Year) 32. Registra Signature State NOV 2 3 2004 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Day November 24, **Physician** Larry Douglas KRETZER 2004 2:20 a.m. /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Continuum Care at Sykesville Sykesville Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) July 29, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1**X**M 2□ F 54 Yrs. 217-52-3385 1950 Director Maryland Usuel Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at 1⊠ Yes 2 No Directo Maryland Carroll Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7309 Second Avenue 21784 USA Funeral 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc filed within 72 hours efter 1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: white ð Specify. 3 ☐ Widowed 4 ♣ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Peges 1 end 2 should be filed within Depertment of Haalth and Mentel Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic event, the Masany injury or other traumatic event, the Masany injury or other traumatic event, the Masany injury or other traumatic event, the Masany injury or other traumatic event, the Masany injury or other traumatic event. Elementary/Secondary (0-12) heavy equipment worker asphalt paving 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Franklin Kretzer Ercel Juanita Knight 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marlene Barger - sister 123 Grand Oak Dr., Hagerstown, Md. 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Hagerstown Crematory 11/24/04 Hagerstown, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MINNICH FUNERAL HOME 21. Signature of Funeral Service Licenses 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as e consequence of) Examine The law raquires that tha death certificate be exacuted signed by the ettending physician and d be datached for usa as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury Due to (or as e consequence of): P.O. Box 68760 Physician/Medical that initiated events resulting in death) Lest Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Division of Vital Records, Š 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed has 1 Yes 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 7 1 ☐ Yes 2XX No 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Director: After Natural 2 Accident 5 Pending death. investigation М 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide in by t Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours aftar To the Funeral Direct 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. ca 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer) 214-2 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

State Registrar DHMH 16 Rev 6/95

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Stoner

32. Reĝistrar's Signature

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	yland		10a. State 10b. County	10c. City	y, Town o	r Location					10d. Inside City Limits
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ĕ	ages ont of S		1 X Burial 2 ☐ Cremation 3 X 4 ☐ Donation 5 ☐ Other (Specification)	Memoval from State		on Cemetery		/2004	St Da	111 N	innesota
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о С	deat	sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No	4 Pregnant at time of d		5 Other (specify)				Month	Day Year
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	To the Hospital or Atlanding Physician: The within 24 hours after death.  To the Funeral Director: Atter this certificate his completely filled in by the funeral director, page	Med	29b. Signature and title of certifier	and manner stated.		29c. License	e number		29d. Date sig	ned (Month	n, Day, Year)
	F ≯F 8		16551	Q		MD	30946		Maria	mlro	22 ) and
	ID		30. Name and address of person who	completed cause of death (Item	n 23a) (Ty	rpe, Print)		24.1	1 4046		22,2004
				hn 1641 m	lont	ose Road	Rocku	ille,	MD	20	832
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ı	Physici /Medic	al	Decedent's Name (First, Middle, Last)      WALTER HARRY      4a. Facility Name (If not institution, give street)	KITTS , SI	₹.	4b. City, Town,	or Location o		2. Date of Death Month NOVEMBER	0		М
	Examin	er	Frederick Memor:		al	Frede		ii Death		Frede		
	Funeral Director		5. Social Security Number 213-42-9143 6. Sex	7. Age (In yrs. I		If Under 1 Yea Months Days	r If Under 2		8. Date of Birth NOV 14, 1	7942	9. Birthplace (State Country) WV	o <i>r Foreig</i> n
	Maryland -f show	tor	Usual Residence of Decedent		, Town or Lo						10d. Inside C	ity Limits
	h with the 23a or 28a at be noti	al Director	10e. Street and Number 18500 ELMER SCHO	OL ROAD		10f. Zip Code 208	342		100	g. Citizen of Wh	nat Country?	
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Registrar

State

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and *		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside C	ity Limits
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3a or	Funeral Director	1789 Shaftsbury A	venue			21114				USA			
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yiding buld be f Mental I arked ol atic eve	To	John Anderson			_		Ве	essie	Edward	s			
and lams		19a. Informant's Name/Relationship				ng Address (Stree							
and and lealth m 27		Barbara K. Swann,	Daughter	20h E		Shaftsb		venue Dat			faryland		
Ges 1 H of H or of or ot		20a. Method of Disposition 1   Burial 2 □ Cremation 3		9		sition (Name of natory or other pla	1				•		
Definition  Definition  Department of mportent: If it any injury or one.		' 4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lic		Fa:		Cemeter		11/23/			eper, V		
Datificate, intal yial permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other treumatic at once.		22 P. Kon				5000 Ann							
		23a. Part1. Enter the disease, or co	mplications that cause	d the deat							/	Approximat	te
Physician		shock, or heart failure. List on Immediate Cause (Final	110 1		0.							Interval Bet Onset and	
/Medical		disease or condition resulting in death)	aDye th (or a		uence of):	eose						109	
Examiner		Sequentially list conditions	Mend	istro	n							1 we	ich
Pa ii	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underthing Cause (Disease or injury that initiated events		s a conseq		111	0 -					1000	
and I-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as	s a conseq	uence of):	I follow	altin	uc					
death certificate be executed death certificate be executed e attending physician and for use as the burial-transit	icai E		CARE	Chri	nii A	I blem	World	Cali	2			1541	-
oo filicate g physias the			d,									-	
O. DOX 00  he death certificate the attending phyched for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Ectopic pregnan	011			2	23d. Date of de	ivery	
death	sicia	in the past 12 months? 1 🗆 Yes 2 🗹 No	4☐Pregnant a			Other (specify)					Month	Day '	Year
at the d by the etach	Phy	9 Unknown			Marie de Marie				an- Dida			***	d
law requires that the de as been signed by the 2 should be detached	by	Part II. Other significant conditions	contributing to death	but not res	uiting in the u	ncerrying cause g	iven in Part	l.	230. Did to		se contribute to		Ohknown
w requires been signe should be	etec								-				
has 10 2	ompleted	<u> </u>							24a. Was autop perfo	an isy rmed?	prior to death?	topsy findings completion of c	ause of
vician: The	e Co	25. Was case referred to medical					26 Plac	e of Death (	1 ☐ Yes Check only o		1 🗆 Yes	2 110	
90 (0 =	0	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpat	ient 2 🗆	ER/Outpatier	nt 3 DOA	th a m				3 □Other (Spe	cify)	
ng Phys ter this	n: T	27. Manner of Death 1 ☐Natural 5 ☐ Pending	28a. Date of Inj (Month, D	ury av Year)	28b. Time of	f 28c. Inju			d. Describe h				
VISION Attending ar death. ector: Afte by the fune	Satio	2 Accident Investigat	ion			M 1[	Yes 2	_					
or Att	ertification:	3 Suicide 6 Could not 4 Homicide determine	288. Place of it	njury - At ho etc. <i>(Specif</i>	ome, farm, str /y)	eet, factory, office	9	28	f. Location (S City or Tox		d Number or Ri )	ural Route Num	iber,
To the Hospitel or Attending F within 24 hours after death. To the Funerel Director: After I completely filled in by the funerel	O	29a. Certifier 1 Certifying	Physician: To the bes	t of my kee	wiedne deat	h occurred at the	time date a	nd place, and	d due to the	causo(c)	and manner as	hateta	
e Hos 24 hc e Fun etely	edicai		aminer: On the basis and manner s	of examina									5)
To th To th	Me	29b. Signature and title of certifier	1/1			29c. Licer	nse number	1100		29d. Dat	e signed (Mont	h, Day, Year)	
		Vandel.	Super	us		DO	0/88	180		11	12210	9	
		30. Name and address of person wh	o completed cause of	death (Iten	n 23a) (Type,	Print)		2	i. in		2		11
Grange La		RONALD C. SRUK	o completed cause of M M D , ) 2004	684	VILLA	SE UREZ	en (	ROF	TON /	u).	11114		
Sta		31. Date filed (Month, Day, Year)	2004 32. Highs	trans Signa	ature.	houle		/					
Regist													

			For State Registrar	State of M	aryland		partment of learning		nd Mental Hy	giene Reg. No. 20	04	39265
	Physici	20	1. Decedent's Name (First, Mic	-					2. Date of De Month		/ear	3. Time of Death
	/Media	al		ce Krass Loew		m			DECEM	BER 01,20		8:15 A M
	Examir	ier	4a. Facility Name (If not institut				4b. City, Town,		Death			%.T
	Funeral		RAVENWOOD LUT  5. Social Security Number	6. Sex 7. A	ge (In yrs. la	ast birthda	HAGERS y) If Under 1 Year	If Under 24	Hrs. 8. Date of Bir	WASHI		ice (State or Foreign y)
	Director		115/07/3962	1 ☐ M 2 🕅 F	89	Yrs.	Months Days	Hours	Min. Decembe	r 25,	New	York
	and *		Usual Residence of Decedent 10a. State 10b. Cour	nty	10c, City	. Town or	Location				100	d. Inside City Limits
	Maryla f sho	ō		nington	,		Hane	rstown				1X Yes 2 □ No
	r 28e	rec	10e. Street and Number		1		10f. Zip Code	LOCOWII		10g. Citizen of Wh	nat Countr	y?
	th with	Funeral Director	1183 Luther	Dr.				21740		U.	S.A.	
	r dea tems	neur	11. Marital Status	12. Was Decedent Armed Forces	?	S. 13	l. Was Decedent of If Yes, specify Cut	Hispanic Originan, Mexican,	n? (Specify Yes or No Puerto Rican, etc.)	14. Race Black,	America White, et	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23a or 28e-f show many injury or other traumatic event, If a Modical Exactine runal be routiled at Once.	by Fi	1 ☐ Never Married 2 ☐ M 3X Widowed 4 ☐ Divord	If Vac Give			1 ☐ Yes 2 No	Specify:		Specify:	Whit	e
Baltimore, Maryland 21215-0036	2 hou	ted	15. Deced	lent's Education	1	16a. Dec	edent's Usual Occu	pation		16b. Kind of Bus	iness/Indu	ustry
215	within 72 ene. then "nat	Completed	(Specify only hig Elementary/Secondary (0-12	thest grade completed)  College (1-4or	5+)	life	edent's Usual Occu re kind of work done DO NOT use retire	a during most o	or working			
21	filed wil Hygien othar th	Con	12	+2			Housewi		A1 (****	Homer		
and	tal H	Be	17. Father's Name (First, Midda)  Nathan 1						s Name (First, Middle,	, малавп Битатв,	,	
Z Z	2 should be and Mental is marked o	2	19a. Informant's Name/Relation			19b. Ma	iling Address (Stree		da Keller or Rural Route Numb	er. Citv or Town. S.	tate. Zip C	Code)
≅	od 2 s lith an 27 is r trau		Peter Loewenh						Hagerstown			
ē,	s 1 ar if Hea itam other	1	20a. Method of Disposition		20b. Pl	lace of Dis	position (Name of ematory or other pla	1	Date	20c. Location - C		
E O	Pages nent of int: If it		1 ☐ Burial 2 ☐ Crematic  1 ☐ Donation 5 ☐ Other	on 3 Removal from State (Specify)	3		rg Cremat	1 2/1	ecember 3, 2004	Smithsbu	ırg M	aryland
alti	permit. Departrimports any inju	1	21. Signature of Funeral Servi	ce Licensee		- 1	22. Name and Addr			avis Fune		
	205 29		JoHney.	Le Davis	MO				Ave. Smith			
_			shock, or heart failure. L	or complications that cause ist only one cause on each	d the death line.	n. Do not e	nter the mode of dy	ing, such as ca	ardiac or respiratory a	rrest,	1	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a		10	Spira	Cord	-al	re	F	en Days
	Examiner			Due to for a	s a consequ	uence of):	Respir	atori	+ Fair	lure,	F	ens Yre
	h	ē	Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	s a consequ	uence of).	-/		0		-	
	outed nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	5 Chro	nic	· OI	bstrue	tive	Pulmon	ary Dis	Case	Mary Yo.
760,	te be executed ysician and ie burial-transit		resulting in death) Last	Due to (or a	s a consequ	uence of):				·		
		dicai		d								
89 X	leath certificat attending phy f for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome	e of pregna	nev				23d. Date	of deliven	,
Вох	death of atten	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	death 3	B □Ectopic pregnand □ Other (specify)	су		Mont Mont		Day Year
a o	0 0 2	hysi	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown							_	
K. Alice ecords, P.	law requires that the as been signed by th 2 should be detache	ру Р	Part II. Other significent cond			_		iven in Part I.	23e. Did t	obacco use contrib	ute to the	cause of death?
A1 ords	w require been sig should b	ted		0010 1)3	rpr	3) 10	51		1□'	Yes 2□No 3	Probal	bly 450Unknown
ĕc.	has be	Completed							24a. Was	psy pri	or to com	sy findings available pletion of cause of
ĭ E	ate pa	Con							t ☐ Yes		ath? ]Yes 2	No
LOEWENHEIM islon of Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to med examiner?	Hospital:				thor	of Death (Check only of		- 3	-
o E	Phys r this sral di	): To	1 Yes 2 No 27. Manner of Death	28a. Date of Inj (Month, D		28b. Time	of 28c. Inju	ary at	sing Home 5 Resi	how injury occurred		
)EW	nding f th. r: After e funer	atior	1 Matural 5 ☐ Per 2 ☐ Accident inve	nding (Month, D estigation	ay Year)	Injury		ork? ∐Yes 2∐No	o			
LOEW Division	or Attand after death Diractor: / in by the f	Certification:	3 ☐ Suicide 6 ☐ Cou	ald not be 28e. Place of Ir	njury - At ho	ome, farm,	street, factory, office	•	28f. Location (	Street and Number	or Rural	Route Number,
Ö	spital or A ours after narel Dira filled in by	Cerl		Salishing, C	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,							
	Fu th	edical	(Check only 2 Medic	fying Physicien: To the bes cal Examiner: On the basis	of examinat							
	To the Hos within 24 h To the Fur completely	Med	one) 29b. Signature and title of cert	and manner s	tated.		29c. Licer	ise number		29d. Date signed	(Month, D	ay, Year)
	F ₹ F 8		MATA	1			7	354	97	12-	2 - 3	24
. 1	4-3		30. Name and address of pers	son who completed cause of	death (Item	23a) (Typ	e, Print)		/			1 à
D	1.		TANVIR F	7. PASHA 1	40	112	2 OPA	L. CT.	HAGER	5 7000.	A)	12 2/7/0
	Sta		31. Date filed (Month Day Ye	0 3 2004 32. Régis	trar's Signa	ture	Sperker					10 2/7/2
	Regist	rar		-10.								

Certificate of Death

Physician /Medical Examiner

**Funeral** Director

filed within 72 hours after death with the Maryland other than "natural", or Itams 23a or 28a-1 show vant, the Medical Examiner must be notified at permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is markad oth any jinry or other traumatic evant 2008.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

and Il-tran attending physician a for use as the burialed by the a signed by peen has certificate director. this

The law requires that the death certificate be executed or Attanding Physician: After t the Diractor: within 24 hours a To the Funaral D To the Hospital

Be

2

Certification:

25. Was case referred to medical examiner?

5 Pending

investigation

6 Could not be determined

1 ☐ Yes 2 No

27. Manner of Death

Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

Division of Vital Records, P.O. Box 68760.

Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29b. Signatura 101(CTG MCCAL completed cause of death (Item 23a) (Type, Print) alen 32. Registrar's Signature 31. Date filed (Mon P D ), Year State 2004 Registrar DHMH 17 Rev 1/2001

28a. Date of Injury (Month, Day Year)

1 - State Registrar I. Decedent's Name (First, Middle, Last) 2. Date of Death Month Laura Belle Lynch December 2004 11:15 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Homewood Retirement Center Williamsport Washington If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) Months 1 ☐ M 2 🕱 F West Virginia 236-58-1525 April 21,1938 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10116 Sharpsburg Pike USA 21740 Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 Yes 2√ No Specify: 3 ₩idowed 4 Divorced þ White leted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Compl Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Robert Harold 0dessa Florence Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry Lynch - Son 11015 Decker Avenue Hagerstown, Maryland of Disposition (Name of Date 20c. Location - City or 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park Dec.6,2004 Hagerstown, Maryland 21 Signature of Funeral Service Licensee Osborne Funeral Home, P.A. 21795 425 S. Conococheague St. Williamsport, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4 Pregnant at time of death 9 ☐ Unknown 9 Unknow Part II. Other significant condition contributing to death but for resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ANDIOUNYOUA 1 Yes 2 🗆 No 3 ☐ Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 25

26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

М

		Please	ype or Print				-	•	
		For	State of Mar				Mental Hygi		1 0005-
		1 - State Registrar		Ce	rtificate of	Death	Re	19. No. U U	4 39267
	*	1. Decedent's Name (First, Middle, Last	)				2. Date of Death		3. Time of Death
Physic /Med		Henr	y Frede	rick L	udder		Novembe:	$r^{\frac{Day}{2}4}$ 20	3:50 AM
Exam		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Deat	h	4c. County o	f Death
		Frederick Memori	al Hospita	1	Freder	rick		Frede	erick
Funera		Social Security Number     Security Number		(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)
Directo		127-20-3623	<b>X</b> M 2□F	77 Yrs.	,		April 10	, 1927	New York
pu .		Usual Residence of Decedent  10a. State 10b. County		IOc. City, Town or Lo	neation				10d. Inside City Limits
aryla sho	-			•					1 ☐ Yes 2 ☒ No
he M 1888-1	Directo	Maryland Frederic	k	Mt. A				D= 0161====== 4.144	
with t	ä	10e. Street and Number	1. D 1		10f. Zip Code	7 1		Og. Citizen of WI	
s 23	Funeral	13220 Jesse Smit	12. Was Decedent Ev	- 11 C 12	2177		Consider Von er No		d States - American Indian,
ltem	- nu	11. Marital Status  1 □ Never Married 2 ☑ Married	Armed Forces? 1 ⊠Yes 2 □ No		Was Decedent of H If Yes, specify Cubi	an, Mexican, Puerl	to Rican, etc.)		, White, etc.
rs aff	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	WWII	1 ☐ Yes 2 ☒ No	Specify:		Specify:	White
Po Pon	ed	15. Decedent's Edu	ucation	16a. Dece	dent's Usual Occup	pation	T .	16b. Kind of Bus	iness/Industry
U Z U	per	(Specify only highest grad	de completed) College (1-4or 5+)	life.	kind of work done DO NOT use retire	during most of world)	rking		
Iryland 21215-0036  should be filed within 72 hours after death with the Maryland of Mental Hygiene.  marked other than "natural, or flems 23a or 28a-1 show marked other than "natural, or flems 23a or 28a-1 show marked other than "natural Examinating and the modified Examinating and the modified and the second.	Completed	Clamentary/odcorloary (0-12)	4		itectural	Histori	an	Municip	al Government
a file othe	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nar	me (First, Middle, A	laiden Surname	)
arylan should be nd Mental marked (	To E	Henry F. Ludder,	Sr.			Irene	Bindrim		
ire, Maryland 21215-5-0035 s 1 and 2 should be filed within 72 hours aft if Health and Mental Hygiene, item 27 is marked other than "natural; or other traumatic event, the Medical Expiri	Г	19a. Informant's Name/Relationship (T)	ype, Print)	19b. Maili	ng Address (Street	and Number or Ru	ural Route Number,	City or Town, S	itate, Zip Code)
C = '4 L		Virginia K. Ludde	r / Wife	13220	Jesse Sm	nith Road	Mt. Air	y, Mary	land 21771
or He fiter		20a. Method of Disposition	Domestal from State	20b. Place of Dispo cemetery, cres	osition (Name of matory or other pla	ce) N		20c. Location - C	City or Town, State
		1 ☐ Burial 2 ☒ Cremation 3 ☐ f '4 ☐ Donation 5 ☐ Other (Specify)		Frederic	k Cremato	$ry \mid \frac{NOV}{26}$	ember 2004	Frederi	ck, Maryland
Baltim permit. Pag Department Important: I		21 Signature of Funeral Service Licens	600	2:	2. Name and Addre				Homes, P.A.
Depa Depa Impo		100 1A	magnetic of the state of the st						aryland 21771
		23a. Part1. Enter the sease, or comp shock, or hear filure. List only of	lications that caused to	ne death. Do not en	ter the mode of dyir	ng, such as pardia	c or respiratory arre	est,	Approximate Interval Between
Physiciar		Immediate Cause (Final disease or condition	Car		hem:	1 (2)	14re		Onset and Death 3 Days
/Medica	_	resulting in death)	aDue to (or as a	Insequence of):	· Itali	101	141		_ J Day 3.
Examine			`	,					/
	Je l	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence of):					
cuted nd ransi	Examiner	that initiated events	c						
BOX 68760, eath certificate be executed attending physician and for use as the burial-transit		resulting in death) Last	Due to (or as a	consequence of):					
1760 Ite be e Iysician ne buriè	ical		d						
filical rtifical ng phy as th	by Physician/Med	IF FEMALE:							
Box eath cert attending for use	an/	23b. Was decedent pregnant	23c. If yes, outcome of 1 Live birth 2		☐Ectopic pregnance	y		23d. Date Mont	of delivery h Day Year
odea heat	Sici	in the past 12 months? 1 Yes 2 No	4☐Pregnant at ti		Other (specify)		-	MON	h Day Year
P.O	h'S	9 Unknown						- 1	
I Records, P.O. Box 68 The law requires that the death certifical ate has been signed by the attending phyage 2 should be detached for use as the	þ	Part II. Other significant conditions co		not resulting in the u	inderlying cause giv	ven in Part I.			oute to the cause of death?
w require been si	Completed	Epidural a	p-scess				1 🗆 48	s 20 No 3	Probably 4 Unknown
Hecc le law r has be ge 2 sh	ple						24a. Was ar autops	y pr	ere autopsy findings available for to completion of cause of
The The page	No.						perform 1 □ Yes 2		eath? Yes 2 No —
ian:	Be (	25. Was case referred to medical examiner?					ath (Check only one	9)	
nysic hysic nis ce I dire	10	1 ☐ Yes 2 X No	Hospital: Inpatient	2 ER/Outpatie	nt 3□ DOA Ot	her: 4 Nursing H	dome 5 Reside	nce 6 🗆 Other	(Specify)
Division of Vital Records, or Attending Physician: The law requires that after dath.  Director: After this certificate has been signe in by the tuneral director, page 2 should be of		27. Manner of Death  1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day)	Year) 28b. Time o	of 28c. Injui	ry at rk?	28d. Describe ho	w injury occurre	d
SIO endii eath. or: A	Certification:	2 Accident investigation			M 1 🗆	Yes 2 □No			
DIVI;	ij	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, st (Specify)	reet, factory, office		28f. Location (Sti City or Town		r or Rural Route Number,
Ital o									
Hosp 4 hour Fune ely fil	Medical	(Chack ροίν 2 Medical Exam	sician: To the best of iner: On the basis of e						
	. 0	one)	and manner state	ed.	200 Licent	co number	20	ad Data signed	(Month, Day, Year)
hin 2 the the	- e	20h Cionati ral andititla of contition			29c. Licens	90 HBHHD01	23	/u. Date signed	incini, way, roar,
Division of Vital Re To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Me	29b. Signature and title of certifier		2	2	01/10		13/2/	1
To the I within 2 To the I complete	Me	) Show		iren, m		51643	•	11/24)	log
To the 1 within 2 To the 1 complet	Me	29b. Signature an Atitle of certifier  30. Name and address of person who c				51643	1	11/24)	109
15	W	30. Name and address of person who o		ath (Item 23a) (Type,		51643 Freden	ick m	11/24) D 2/:	702

			For State Registrar		/larylan	d / Depa	artment of I	Health Death	and M	F	Reg. No.	004	39268
П	Physici	an	<ol> <li>Decedent's Name (First, Middle, Graham Melvin</li> </ol>							2. Date of Dea	Day	Year	3. Time of Death
	/Medic		4a. Facility Name (If not institution,				4b. City, Town,	or Location		Nov 21,	7	nty of Death	1015 P M
	Examin	er	Charlotte Hall				Charlott					Mary'	s
	Funeral		5. Social Security Number	6. Sex 7. /	Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under		8. Date of Birt	h	9. Birthr	place (State or Foreign
	Director		218-03-9106	1 <del>∕</del> M 2□ F	83	Yrs.				Aug 3	1921	Mary	land
	land bw		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation						10d. Inside City Limits
	Mary P-f sh	tor	Maryland Calve	ct	Sol	omons.							1 ☐ Yes 2 🛣 No
	th the	lrec	10e. Street and Number				10f. Zip Code				10g. Citizen o	of What Cou	ntry?
	ath wi	ral	11750 Asbury Cir				2068					ed Sta	
	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show tra Medical Exatin are invalled in all the state of th	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Marrie	12. Was Deceder Armed Force ad 1X Yes 2	s?	. <b>S</b> . 13.	Was Decedent of If Yes, specify Cub	Hispanic Or oan, Mexica	igin? (Sp n, Puerto	ecify Yes or No- Rican, etc.)	14. R	lace · Americ lack, White,	
336	urs aft		3 □ Widowed 4 □ Divorced	If Yes, Give Year or Dates	3:		1⊡ Yes 2⊡ <b>x</b> No	Specify:	:		Spec	city: whi	te
21215-0036	72 hou	Completed	15. Decedent' (Specify only highest	s Education	WWII	16a. Dece	dent's Usual Occu	pation	t of work	ing	16b. Kind of	Business/In	dustry
2	ithin "ner	nple	Elementary/Secondary (0-12)	College (1-4c	or 5+)		kind of work done DO NOT use retire	ed)	N OF WORK	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
7	iled w Hygier Iher ti		12 17. Father's Name (First, Middle, L	asti		contr	actor	18 Moth	er's Name	e (First, Middle,	comst		n
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural; or items 23e or 28e-f show any injury or other treumetic event, the Medical Exchange in unable notified at ance.	To Be	Oscar Martin Lev							ne Eva (		aille)	
ary	s mar	<b> -</b>	19a. Informant's Name/Relationsh				ng Address (Stree				-	vn, State, Zip	Code)
Σ,	and 2 ealth a n 27 I		Charles Lewis, S	Sr son	1		Carroll						
Baltimore,	ges 1 it of H if Itel		20a. Method of Disposition 1 □ Burial 2 □ Cremation				osition (Name of matory or other pla				20c. Location		own, State 'irginia
謹	urtmen intent: injury njury		' 4 ☐ Donation 5 ☐ Other (Sp 21. Sign fure ☐ Funeral Service L		Met		tan Fune			ce			_
Ba	Departiment of the permitted of the perm	l q	DRO			4.4	2. Name and Addr	T-	"Raus	sch Fune	eral Ho	ome PA	MD 20676
			23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that caus	ed the deat	h. Do not en	ter the mode of dy	ing, such as	cardiac	or respiratory ar	rest,	DILC	MD 20676 Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	-		COVA.	S CULL	102	Acc	CIDEN	T		Onset and Death
	/Medical Examiner		resulting in death)		as a conseq								
		e	Sacuar finity list conditions if any, leading to immediate	b. Due to (or a	as a conseq	uence of):							
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	â									
o,	e exectian an	Exa	resulting in death) Last	Due to (or a	as a conseq	juence of):							
8760,	cate be executed oblysician and the burial-transit	Physician/Medical		d									
9	certifica inding pl use as t	/Med	IF FEMALE:	23c. If yes, outcom	ne of preon:	ancv					224 5	Date of deline	
Вох	eath certifi attending I for use as	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant	2 Feta	II death 3	Ectopic pregnand Other (specify)	у				Date of delive Month	Day Year
P.O.	that the de ed by the detached	hysl	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown									
	The law requires that the death certificate be executed te has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	by P	Part II. Other significant condition	01.0		-							he cause of death?
Vital Records,	w requir been si should	ted	DENIENTA	CHICENT	C OF	SPIKUC	TIVE P	1CMB	NATC	1 U Y	es 2□No	3 □ Prob	pably 4 @Onknown
Sec.	has by	Completed	ON SEASE, PAR	KINSON,	150	HEMI	C COLI	775		24a. Was autop	sy	b. Were auto prior to co death?	psy findings available mpletion of cause of
a T			DEPRESSION	ACUTE	RENA	Z 1W.	SUPFICE	ENCY		1 ☐ Yes	2 NO	1 Yes	2 10
ξ	sicler certif	o Be	25. Was case referred to medical examiner?	Hospital:	tiont 2	ER/Outpatier	nt 3 DOA Ot	hor	of Death	n (Check only o	<i>ne)</i> lence 6 □C	Athor (Care	
10	무무등	$\vdash$	27. Manner of Death	28a. Date of In		28b. Time o				28d. Describe h			y)
ion	Attending Pher death.	atlo	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investig	ation	Jay I Gai)	injury		Yes 2	No				
Division of	I or Attending Physiclen: after death. Director: After this certifica I in by the funeral director, i	Certification:	3 Suicide 6 Could n 4 Homicide determi	ned 286. Place of	Injury - At hetc. (Specif		reet, factory, office			28f. Location (S City or Tow	itreet and Nur n, State)	mber or Rura	al Route Number,
	pitel ours a lerel Distribution of the control of t		29a. Certifier 1 Certifying	Physicien: To the be	et of my kno	teah aphalwo	h occurred at the t	ime date ar	nd place	and due to the	ause(s) and	manner as s	tated
	To the Hospitel within 24 hours of To the Funeral completely filled	edical	(Check only 2 Medicel E	xaminer: On the basis and manner	of examina	ation and/or in	vestigation, in my	opinion, dea	ath occur	ed at the time,	date and place	e, and due to	the cause(s)
	To the Hospitel within 24 hours a To the Funerel Completely filled	Me	29b. Signature and title of certifier	101.				se number			29d. Date sign	1	e1
			pulp	fr-fully	En			050	056	3	11/5	22/	2004
F	141		30. Name and address of person v	who completed cause of	f death (Iter	m 23a) (Type,	Print)	HAR	100	3 TE HE	4.1	MD	
	ו וע Sta	ite	31. Date filed (Month, Day, Year)	2 3 2004 ≥	strans Signa	ature	IVEL, C	WATE	40/1	C 1116	1		
	Registi		NOV	2 3 2004	Blown	UK	Aporte	P					

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	Dhysisi		1. Decedent's Name (First, Mide	die, Last)								2. Date of Deal Month	Day	Year	3. Time of Death	1
	Physicia /Medic		Christa		L	ynett	е	Lav	vson			Novembe	r 23,		7:22 P	М
7	Examin		4a. Facility Name (If not instituti	on, give street	and number)					Location of				ounty of Dea		
			702 Rear	Shrive	r Aven	ue				erlan				11ega		
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2			ast birthday)	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Birth (Month, Day 07/17/1	Year)	9. Bir	thplace (State or Forei ountry)	ign
	Director		217-04-8271	1011112	-631	33	Yrs.					07/1//1	9/1	Mai	yland	
	pug *	}	Usual Residence of Decedent  10a. State 10b. Count	tv		10c. City	, Town or Lo	cation							10d. Inside City Limi	its
	72 hours after death with the Maryland naturel', or Items 23e or 28e-f show dical Examinar must be notified at	ö		legany			Cumb	erlan	.d						1X Yes 2 □ N	No
	1he N	ect	10e. Street and Number					10f. Zip	Code			1	0a. Citize	n of What C	ountry?	_
	with	Funeral Director	702 Rear Sh	river A	venue			101124		502			US		,	
	eath	eral	11. Marital Status	12. W	as Decedent	Ever in U.	S. 13.	Was Deced	ent of Hi	ispanic Orio	gin? (Sp	ecify Yes or No-	14	. Race - Am	erican Indian,	
	lter d	٦	1 Never Married 2 Ma	Ar	med Forces? □Yes 2]{		i					ecify Yes or No- Rican, etc.)		Black, Whi	te, etc.	
336	irs af	þ	3 ☐ Widowed 4 ☐ Divorce	lf lf	Yes, Give ear or Dates:			1 ☐ Yes	2∕∑ No	Specify:			S	pecify:	Thite	
ŏ	2 hou	ted		ent's Education			16a. Dece	dent's Usua	I Occupa	ation			16b. Kind	of Business	/Industry	
715	nin 7:	ple	(Specify only high Elementary/Secondary (0-12)		ollege (1-4or:	5+)	life.	kind of wor DO NOT us	rk done d se retir <b>e</b> d	<i>juring</i> mosi ')	t ot work	ing				
21,	d with	E O	12		4	,		Cot	ınsel	lor			Н	landica	ар	
פַ	e file of the vent,	Be Completed by	17. Father's Name (First, Middle	e, Last)						18. Mothe	er's Name	e (First, Middle, i	Maiden Si	umame)		
<u>lar</u>	Aenta Aenta rked tic e	To	Jackson	I	Paul		Lawso	n		Shi	rley	Kathe	rine	Red	kart	
Maryland 21215-0036	short short		19a. Informant's Name/Relation									al Route Number				
	and 2 alth a 27 i		Shirley K. Law	son / r	nother					Aveni	ue,	NE., Cun				
ore	of He of He item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	2 🗆 🗆 🗆 a may	al from Ctato	Ce	lace of Dispo emetery, crei	natory or o	ther plac					ation - City or		
Ĕ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Items 23e or 28e-1 show eny injury or other traumatic event, the Mardical Examinar must be notified at once.		'4 □Donation 5 □ Other		ai from State	Fa									mith, PA	
Baltimore,			21. Signature of Funeral Service	e Licensee	0	_/	) 22					ams Fami t, Cumbe	•		Home, P., 21502	Α.
			23a. Part1. Enter the disease, shock, or heart failure. Li	or complication	ns that cau	Ine death	Do not ent	er the mod	e of dying	g, such as	cardiac	or respiratory arr	est,		Approximate	
			shock, or heart failure. Li Immediate Cause (Final	st only one cau											Interval Between Onset and Death	
7	Physician /Medical		disease or condition resulting in death)	_ a	Self-		ngulat	ion			_					
	Examiner						ressio	n								
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter those ying Cause (Disease or injury	b. —	Due to (or as	a consequ	uence of):									
	nsit	ië.	Cause (Disease or injury	<b>~</b>												
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	с	Due to (or as	a consequ	uence of):									
760,	ite be ex lysician he burial	cail														
687	ficate physis the			u									-10			
Box	death certificat e attending phy d for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		yes, outcome			-					23	d. Date of de	livery	
m	Jeath atte	cia	in the past 12 months? 1 ☐ Yes 2 ☐ Yo	4	□Live birth □Pregnant a			]Ectopic pr ] Other (sp						Month	Day Year	
P.0.	the y th	Jysi	9 Unknown	9	Unknown											
	w requires that s been signed b ? should be deta	by PI	Part II. Other significant condi	itions contribut	ting to death t	out not resu	ulting in the u	nderlying c	ause give	en in Part I.		23e. Did to	pacco use	contribute t	the cause of death?	
rds	quires n sign											1 🗆 Y	es 2 🗆	No 3□P	robably 4 nknov	wn
Vital Records,	- A	Completed										24a. Was a		24b. Were a	topsy findings availab	ple
Re	sician: The law certificate has t irector, page 2 s	E C										autops	ned?	death?	completion of cause o	of
a	n: T ficate or. pa	e C	25. Was case referred to media	nal						26 Place	of Dogs	1 ☐ Yes	No No	1 🗆 Yes	2 □ No	
₹	Physician: this certific ral director.	00	examiner?	Hospit	al: 1 □ Inpati	-nt 2[]	ER/Outpatier	3 DC	Othe	25		me 5 Reside		Other (Co.	a.i6.i)	
of		1: 70	27. Manner of Death	28	a. Date of Inju (Month, Da		28b. Time o		8c. Injury	/ at		28d. Describe ho			chy)	
o	ding Phy h. After thi funeral o	tion	1 Natural 5 Pend		(Month, De 11/23/2		Injury unknow		Worl 1 □ '	k?	, No	Subject	hun	o hers	elf	
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Division of	after Dire	Certification;	4 Homicide	:	e. Place of In building, e Baseme	tc. <i>"(Specit</i> ) ent R	") esiden	.ce				7 City of Town Cumber I	r State)	riger <sub>1</sub>	Avenue	
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu				n: To the best	of my kno	wledge, deat	h occurred				and due to the c	ause(s) ai	nd manner a	s stated.	
	n 24 h	Medicai	(Check only 2 Medic one)		On the basis of and manner st		tion and/or in	vestigation	, in my op	pinion, dea	th occur	red at the time, d	ate and p	lace, and du	o to the cause(s)	
	To ti Withi To ti comp	Σ	29b. Signature and tille of certi	fier	//			290		e number		2			h, Day, Year)	
	2		1) and	1	Two				D09	157			Nove	mber 2	2004	
			30. Name and address of person Paul Snow,	on who comple	ted cause of	death (Item	1 23a) (Type,	Print)	et	Cumba	e <b>r</b> 1 o	nd, MD	2150	2		
	nds				32. Regist							110				
	Sta Regist		31. Date filed (Month, Day, Xell NOV 2	2004		no signa	19	pou	Ks	1						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician BERNARD THOMAS LAMBERT, SR. 30 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Cumberland
If Under 1 Year If Under 24 Hrs. Allegani MEART DITAL DAcred 9. Birthplace State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1**x** M 2□F Yrs. 60 Director 233-68-3882 1944 West Virginia Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a, State 10b. County or 28a-1 show the Madicul Executiver crust be notified at 1 ☐ Yes 2 X No Director WV Hampshire Paw Paw 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 25434 IISA 23a HC 60 Box 10A filed within 72 hours after death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 M Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than College (1-4or 5+) Elementary/Secondary (0-12) Laborer Excavating 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 Is marked oth any injury or other traumatic svent ang. Be Audrey Sine ပ Glen Lambert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Paw Paw, WV 25434 Betty S. Lambert - wife HC 60 Box 10A 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Nov. 24,2004 \* 4 ☐ Donation 5 ☐ Other (Specify) Wesley Chapel Levels, WV 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kimble Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Paw Paw, West Virginia Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Ancer of PAncreas Mmonths /Medical Due to (or as a consequence of): Examiner ACheXIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed use as the burial-transit sehydration and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician ched for use as the buria Completed by Physiclan/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Day Month Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown peed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? has certificate ARter 2 No ORONARY 1 ☐ Yes 2 X No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification; To Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Tyes 2 No 1 🛛 Inpatient this 28a. Date of Injury (Month, Day Year) To the Funeral Director: After the completely filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Injury 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours a To the Hospital 1 🗵 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License numbe 29b. Signature and Itte of certifier MOVEMBER 24,200 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 92 Mehanna 31. Date filed (Month, Pay, Year) 32. Degistrar's Signature State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.) I. Decedent's Name (First, Middle, Last) 2. Date of Death Month 12-Day Year Lewis 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Allegany 10 N. Liberty Street Cumberland If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Jan 14, 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Months 1 □ M 2 🙀 F 236-40-8584 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b, County MD Allegany Cumberland 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 10 N. Liberty Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: white Specify 3 Noticed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Waitress/Cashier Commissary 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Frederick Franklin Freeland Erma Catherine Freeland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 614 Pine Ridge Road Bedford PA Deborah Fields daughter 15522

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sacrpelli Funeral Home, PA

Date

12/4/2004

20c. Location - City or Town, State

Cresaptown

Month

MD

Year

Day

3 Probably 4 Unknown

Approximate Interval Between Onset and Death

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla Department of Heelth and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Itams 23a or 28a-f ehow any Injury or other traumatic event, Ira Madical Examiliner: ust be rediffied at once.

**Physician** 

/Medical

Examiner

Director

Funeral

þ

Completed

To Be

20a. Method of Disposition

\* 4 ☐ Donation 5 ☐ Other (Specify)

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

**Funeral** 

Director

the Maryland

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

The law requires that the death certificate be executed

or Attending Physician:

Division of Vital Records, P.O. Box 68760,

Examiner physician and s the burial-transit attending p signed by the al page 2 Be

Physician/Medical Completed by

Certification: To Medical

within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director.

22. Name and Address of Facility
Scarpelli Funeral Home, P.A. 21. Signature of Funeral Service Licenses 108 Virginia Avenue; Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or fleart failure. List only one cause on each line. Immediate Cause (Final pima disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Under in Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 70 77 1 □ Yes 2 2 No 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 1 Yes 2 No 4 ☐ Nursing Home 5 Fresidence 6 ☐ Other (Specify) 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Mann of Death Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D54411

State Registrar

Beverly Calkins M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

500 Memorial Ave Ste 105 Cumberland MD 21502

32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

		<ol> <li>Decedent's Name (First, Middle, La.</li> </ol>	st)				2. Date of De Month	aath Day	Year	3. Time of Death
Physici /Medic		LINDS	EY MAY	McG	INNIS		NOV.	21,	2004	5:30 A
Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Tow	n, or Location of D	eath		unty of Death	
		ST. THOMAS MO 5. Social Security Number 6. S		HOME   e (In yrs. last birt)		YATTSVIL par If Under 24				GEORGES uplace (State or Fore
uneral irector			I		Yrs. Months Da		Hrs. 8. Date of Bin (Month, Date of MAY 25	iy, Year) - 1911	Cou	RGINIA
		Usual Residence of Decedent						, -,		
show	5	10a. State 10b. County		10c. City, Town						10d. Inside City Lim 1 ▼Yes 2 ☐ I
28a-f	ecto	D.C. NONE  10e. Street and Number			WASHIN 10f. Zip Coo			10g. Citizen	n of What Cou	
3a or		645 EMERSON	CT NE			0017		•	U.S.A.	•
ms 2	by Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?				? (Specify Yes or No uerto Rican, etc.)		Race - Ameri	ican Indian,
or Ita	F	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 1		1 ☐ Yes 2 【X		deno rican, etc.)		Black, White	, etc.
urel',	d b	3 XWidowed 4 □ Divorced	Year or Dates:	1 40-					BL	ACK
"nat	Completed	15. Decedent's E. (Specify only highest gra	ade completed)		Decedent's Usual Oc (Give kind of work do life. DO NOT use re	ne during most of	working	16b. Kind	of Business/Ir	naustry
the	J Wo	Elementary/Secondary (0-12)	College (1-4or 5	5+)	CUSTO			U.S	GOV'	т.
othe vent.	Bec	17. Father's Name (First, Middle, Last,	)	· · · · · · · · · · · · · · · · · · ·		18. Mother's	Name (First, Middle	, Maiden Su	mame)	
rked tic e	To	ELMOND	REDD				MARIAH	T	CAYLOR	
r nealin and wenter hyperia ryperia. It is marked other then "naturel", or items 23a or 28a-f show other traumatic event. The Madical Examinational to invitited at		19a. Informant's Name/Relationship (			. Mailing Address (Str					
m 27		ELDORA C. ROBINS	SON/FRIEND		Disposition (Name of		.E., WASH		ion - City or T	
Department of Health a Importent: If Item 27 Is any injury of other tra		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □		cemeter	y, crematory or other	place)				
n de la la la la la la la la la la la la la		<ul><li>4 ☐ Donation 5 ☐ Other (Special</li><li>21. Signature of Funeral Service Lice</li></ul>		GLEN	WOOD CEME	TERY   11	-27-2004	WASH	IINGTON	, D.C.
mpo any i		21. Signature of Fulleral Gervice Lice		_	22 Name and Ac	Idrace of Facility				
	1 1	21/01/(K	ambusa	M00091	CHAMBERS	FUNERAL	HOME & C	REMATO	RIUM, P	A.
ysician		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused one cause on each fi	ine. Ensive c	CHAMBERS 5801 CLE not enter the mode of CARDIOVASC	FUNERAL VELAND A' dying, such as car	VE., RIVE	RDALE,	PRIUM, P MD. 2	20737 Approximate Interval Between Onset and Death
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MOULDEN MARTHA.

			_ State		artment of Health and N tificate of Death			
	0.5		Registrar  1. Decedent's Name (First, Middle, Last)		incate of Beatif	2. Date of Death	2001	3. Time of Death
	Physicia		Martha Jean Moulden			November November	19, 2004	
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death	1	4c. County of Death	·
			Holy Cross Hospital		Silver Spring		Montgomer	
п	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. I	Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	ear) 9. Birth	place (State or Foreign intry)
	Director		577-30-0897 77 Usual Residence of Decedent			Dec 10, 1	1920 Mai	yland
	nylanc how		10a. State 10b. County 10c. City	, Town or Lo	cation			10d. Inside City Limits
	Be-1 s	Director		Lver Sp				1 ☐ Yes 2X No
	with the		10e. Street and Number		10f. Zip Code		. Citizen of What Cou	intry?
	eath is 23	Funeral	10 000 Brunswick Ave, #406  11. Marital Status 12. Was Decedent Ever in U.	S. 13.1	20910 Was Decedent of Hispanic Origin? (Sp		JSA 14. Race - Ameri	ican Indian,
Maryland 21215-0036	i within 72 hours after death with the Maryland liene. r then "natural", or Items 23e or 28e-f show Ite Medical Evaninat must be notified at	by Fun	Armed Forces?  1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	1	f Yes, specify Cuban, Mexican, Puerto I ☐ Yes 2☑ No Specify:	o Rican, etc.)	Black, White	
2-0	72 hou	ted	15. Decedent's Education (Specify only highest grade completed)	16a. Decec	lent's Usual Occupation kind of work done during most of wor	king 161	b. Kind of Business/In	
21	within 7 iene. • then "r	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. L	OO NOT use retired)	Am 19		
121	filed w Hygier Ither th		12 17. Father's Name (First, Middle, Last)	Hor	nemaker	ne (First, Middle, Mai	Own Home	
anc	e d ta	Be C						
Ž	2 should be and Mental Is marked o	스	Charles Ross Cleaves  19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	g Address (Street and Number or Ru	irginia Lo ral Route Number, C		ip Code)
	s 1 and 2 should if Health and Men item 27 Is marke other traumatic		William Ross Moulden/Son	18406	6 Autumn Field Ct	, Boyds, N	4D 20841	
ore,	of Hei				sition (Name of natory or other place)		c. Location - City or T	own, State
Ë	Page ment and ury o		I Manual 2 Defination 3 Definition State		's Lutheran Cem N	ov 22, 200	04 Winche	ster, VA
Baltimore,	permit. Pages 1 Department of H Important: If ite eny injury or oth		21. Signature of Funeral Service Licensee		Name and Address of FacilityHin BOO New Hampshire			
			23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	. Do not ente	er the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
	Enysician	É IV	Immediate Cause (Final disease or condition a. Intra	acrani	al Hemmorhage			Onset and Death
	/Medical Examiner		Due to (or as a consequ	ience of):				
		-E	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of the conditions)	uence of):				
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury) that initiated events  c.					
ó	ficate be executed g physician and ts the burial-transit		resulting in death) Last Due to (or as a consequence of the consequenc	uence of):		•		
68760,	ate be hysicii he bu	edical	d			·		
			IF FEMALE:					
.O. Box	The law requires that the death certificate has been signed by the attending tage 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2√2 No 9 □ Unknown  23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)		23d. Date of deliv Month	Day Year
Δ.	s that ned b e deta	by Pł	Part II. Other significant conditions contributing to death but not rest	ulting in the ur	nderlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
rds	w requires been sign should be					1 🗆 Yes	2 □ No 3 □ Pro	bably 4X Unknown
Records,	The law re ate has bee page 2 sho	ompleted				24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of
Vital	icien: T	Be C	25. Was case referred to medical examiner?			th (Check only one)		
of \	hys nis I dii	은	1 ☐ Yes ※☐ No Hospital: 1 ※Inpatient 2 ☐			ome 5 Residenc		(fy)
nc	ting F	:lon:	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	
Division	Attenc death ctor: y the	flcat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At he	me, farm, str		28f. Location (Stree	t and Number or Rur	al Route Number,
οi	al or A	Certification;	4 ☐ Homicide determined building, etc. (Specify	City or Town, S	State)			
	To the Hospital or Attending P within 24 hours after death.  To the Funeral Director: After the Completely filled in by the funeral completely filled in the funeral completel	Medical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my kno 2 Medical Examiner: On the basis of examina and manner stated.	wledge, death tion and/or in	n occurred at the time, date and place vestigation, in my opinion, death occu	, and due to the caus rred at the time, date	e(s) and manner as and place, and due to	stated. to the cause(s)
	withii To th	Ä	29b. Signature and title of certifier	$\gamma$	29c. License number	1	Date signed (Month,	
•	15		· Our > ref	7	D37891	No	vember 20,	2004
	( -	- 6	30. Name and address of person who completed cause of death (Item			rillo MD	20852	
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signa		1 Ln, #409, Rocky	TITE, PID	20072	
	Registr		NOV 2 4 2004	Ø	Sparks			

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANA RUSIO, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

NOV 2 9 2004 Denura

& sparks

		State of Maryland / Depar	tment of Health and M ificate of Death		2001.	39276
		Registrar  1. Decedent's Name (First, Middle, Last)	ilcale of Dealit	2. Date of Death	NE- UU4	3. Time of Death
Physici /Medic		DONALD CHARLES MILIER		Month November		12:00 P <sub>M</sub>
Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	
	1	-, os brookshire kun	Point of Rocks		Frederick	
Funeral Director			If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	B. Date of Birth (Month, Day, Yo May 4, 19	9. Birt 946 Mic	hplace (State or Foreign untry) hagin
Ð ,		Usual Residence of Decedent         10c. City, Town or Local           10a. State         10b. County         10c. City, Town or Local	Ainn			10d, Inside City Limits
anylan show	_					1 ☐ Yes X☐ No
the M.	Director	Maryland Frederick Point of Ro		100	. Citizen of What Co	
with t		10e. Street and Number	10f. Zip Code			•
eath is 23	era	1709 Brookshire Run  11. Marital Status   12. Was Decedent Ever in U.S.   13. Wa	21777 as Decedent of Hispanic Origin? (Spe		ited Stat	
inc, with yield A 12.15.0000 s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then 'naturel', or Items 23e or 28e-1 show other treumetic event, the Madical Examiner must be ruitlised at	by Funeral	Armed Forces?  1 Never Married 2 Married  1 Tyes 2 No  1 Yes, Give	es, specify Cuban, Mexican, Puerto I Yes 2 X No Specify:	Rican, etc.)	Black, White	e, etc.
72 hours	eted b	3 Widowed 4 Divorced Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  16a. Deceder (Give kir	nt's Usual Occupation	16	b. Kind of Business/	Industry
within iene. r then	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 4 Manager	NOT use retired)		rlines Re	eporting Corp
ent,	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Mai	iden Sumame)	
2 should be filed with and Mental Hygiene. Is marked other ther eumetic event, the N	To B	Charles Miller II		nham		
d 2 should th and Men (7 is marke treumetic		19a. Informant's Name/Relationship (Type, Print) Linda Marie Cox/Wife	Address (Street and Number or Rura cookshire Run, Po	<i>int</i> of Ro	ity or Town, State, 2 ocks, MD, 2	?ip Code) ?:1777
is 1 and of Health item 27 other to		20a. Method of Disposition 20b. Place of Disposition	tion (Name of D	ate 20	c. Location - City or	Town, State
Pages ment of h		4 Donation 5 Other (Specify) Frederick	Crematory 11/28			Maryland
pariting of the part of Health a Importent: If item 27 is any injury or other tree			Name and Address of FacilityStau 00 North Maple Av			21716
		23a. Part 1. Enter the divease or complications that caused the death. Do not enter shock, or heart fature. List only one lause on each line.	the mode of dying, such as cardiac o	r respiratory arrest	,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)  a. HEPATO CELLUI	LAR CARCINON	14		Onset and Death  3 MONTUS
/Medical Examiner		Due to (or as a consequence of):	2			SEVERN YRS
D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				<u>,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,</u>
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cate be executed physician and the burial-transit	dicai E	d				
ng ph	Med	IF FEMALE:				
LIVISION OF VICE INCOMES, I. C. DOX OUT OUR WAR INCOMES, I.C. DOX OUT OUT, To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?	ctopic pregnancy Other (specify)		23d. Date of deli Month	ivery Day Year
hat the sed by detac		Part II. Other significant conditions contributing to death but not resulting in the und	erlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
requires sen sign	ted by			1 ☐ Yes	2 No 3 Pr	obably 4 Unknown
The law r te has be age 2 sh	Completed			24a. Was an autopsy performe	prior to death?	topsy findings available completion of cause of
len: len: rtifica stor, p	O	25. Was case referred to medical	26. Place of Death		, NO 12155	
ysic ysic direc	To B	examiner?  1   Yes   2   No	3☐ DOA Other: 4☐ Nursing Hor	me 5 Residenc	e 6 Other (Spec	cify)
ing Pt		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury 28b. Time of Injury	Work?	28d. Describe how	injury occurred	
ttend death ctor: / the f	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined and the country of the count	M 1 Yes 2 No	28f. Location (Stree	at and Number or Ru	ıral Route Number.
s after s afte	Certification:	4 Homicide determined building, etc. (Specify)	, satisfy, smoo	City or Town, S		
To the Hospitel or Attending Physicien: The law requires that the de within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the accompletely filled in by the funeral director, page 2 should be detached.	edical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death of 2 Medical Examiner: On the basis of examination and/or investant and manner stated.				
To the within To the comp	Me	29b. Signature and tipe of certifier MS	29c. License number 016675		Nov. 26	
10		30. Name and address of person who completed cause of death (Item 23a) (Type, P	BILLIAN DICK	arb.		
St. Regist	ate rar	31. Date filed (Month, Day, Year)  NOV 2 9 2004  Service  NOV 2 9 2004	5 Sparks			

State of Maryland / Department of Health and Mental Hygien 0 0 4 1 - For State Ragistra 39277 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 21 Month **Physician** Year Т Jeannette Maynard 2004 November 9:41  $P^{M}$ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Memorial Hospital Frederick Frederick 8. Date of Birth (Month, Day, Year) AUG. 20, 1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Days 1 □ M 2 🛱 F Months Hours Director 015-14-1672 1919 Canada Usual Residence of Decedent the Maryland show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or items 23a or 28a-1 shov Examiner must be notified at Maryland Frederick Frederick 1 Yes 2X No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filled within 72 hours after death with Innent of Health and Mental Hygiene. 110 Charleston Lane 21702 United States Funeral . Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☑ No Specify: Completed by White 3 Widowed 4 Divorced "natural" or than "natura", the Madical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry U.S. Elementary/Secondary (0-12) College (1-4or 5+) 12 Administrative Assistant Federal Government it of Health and Mental Hygis If item 27 le marked other or other traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Francis Seaver ပ Louise Marie LaVoier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 110 Charleston Lane/ Frederick, Maryland Emil S. Maynard / Husband 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or \* 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Mem. Garden |11/27/2004 | Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Licenses Saymon 1621 Opossumtown Pike/ Frederick, MD 21702 lerson 23a. Part1. Over the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Respiratory disease or condition resulting in death) Day S /Medical Due to or as a consequence of): Examiner Se 7515 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to or as a consequence of The law requires that the death certificate be executed burial-transit cellulitis Due to (or as a consequence of): attending physician Physician/Medical as the IF FEMALE: nse use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? jo Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) the should be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23a. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 this certificate has 1 Yes 2 PNo or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital: Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Madicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number D0063180 November 22,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V Street Frederick Rizvi, MD 400 TH allzi West 31. Date filed (Month, Day 32. Registrar's Signature State 2004 Registra Spark

DHMH 17 Rev 1/2001

altimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of F			2004	39278
	Physic /Medi		Decedent's Name (First, Middle     Ada Charlott	e McFaul				2. Date of Death Month November		
	Examine Funeral Director	ner	4a. Facility Name (If not institution  1901 Hidden Po  5. Social Security Number	int Road	(In yrs. last birthday)	Annapol If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y June 21,	Anne Arur  Anne Birtt  9. Birtt  Cot  1914 Penr	
	ō.		217-42-3842 Usual Residence of Decedent  10a. State 10b. County		90 10c. City, Town or Le	ocation		Julie 21,	1714 Felli	10d. Inside City Limits
	with the Ma s or 28a-f s be notified	Directo	Maryland Anne 10e. Street and Number	Arundel	Annapoli	5 10f. Zip Code	<u> </u>	10g	. Citizen of What Cou	1 ☐ Yes 2 ☑ No untry?
920	s 1 and 2 should be filed within 72 hours after death with the Maryland Fhealth and Mental Hygiene. Health and Mental Hygiene titem 27 is marked other than "natural", or items 23a or 28a-f show other treumatic event, the Medical Exemples from the Indifficut at	by Funeral Director	1901 Hidden Po 11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces?		21401 Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No		pecify Yes or No- Dican, etc.)	nited Stat 14. Race - Amer Black, White Specify: wh	ncan Indian,
21215-0036	d within 72 ho giene. or than "natur ire Medical	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education t grade completed)  College (1-4or 5+	(Give life.	dent's Usual Occup kind of work done o DO NOT use retired	during most of work )	king	b. Kind of Business/li	,
Maryland 2	2 should be filed withir and Mental Hygiene. Is marked other than eumatic event, Ira M.	To Be C	17. Father's Name (First, Middle, Informant's Name/Relations)	ası) İrick			18. Mother's Nam	e (First, Middle, Ma . Hair		
			H. Algire McFau  20a. Method of Disposition 1 Burial 2 @Cremation	l/ husband		Hidden P	oint Rd.	Annapolis	MD 2140 c. Location - City or T	)1
Baltimore,	permit. Page Department o Importent: If any injury or once.		14 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service to Sp. 21. Signature of Sp. 21. Si	pecify)	-0,	2. Name and Addres	s of Facility Joh	nn M. Tay	Baltimer lor Funera Annapolis,	1 Home, Inc
	Physician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a	ne death. Do not ent	er the mode of dying	g, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death
8760,		dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	consequence of):					
O. Box 6	The law requires that the death certificate be executed tte has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
Δ,	w requires that been signed b should be deta	by	Part II. Dther significant condition	ns contributing to death but	not resulting in the u	nderlying cause give	on in Part I.	23e. Did tobac	co use contribute to t	
Vital Records,		Completed						24a. Was an autopsy performed	prior to co death?	opsy findings available impletion of cause of
of	Physic this ce al direc	ion: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  Design Street S	28a. Date of Injury (Month, Day)	2 ER/Outpatien 28b. Time of Injury	28c. Injury Work	4 Nursing Ho	me Residence 28d. Describe how i	e 6 □Other (Specification)	(y)
Division	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: Attercompletely filled in by the funer	Certification:	2 Accident investig 3 Suicide 6 Could n 4 Homicide determine	ot be	r - At home, farm, str (Specify)		′es 2□No	28f. Location (Stree City or Town, S	t and Number or Rura tate)	al Route Number,
	To the Hospitel within 24 hours a To the Funerel C completely filled i	edical	one) 2 Medical E	Physicien: To the best of xeminer: On the basis of eand manner state	xamination and/or inv	occurred at the tim restigation, in my op	e, date and place, inion, death occurr	and due to the caus ed at the time, date	e(s) and manner as s and place, and due to	tated. o the cause(s)
)	Nith Con	Σ	29b. Signature and title of certifier	Mul	inte	29c. License	8194		Date signed (Month,	Day, Year)
			30. Name and address of person v Jack R. Lichtens	tein 205 Ridgely	Avenue, An	,	21401			
	Sta Registr	- 4	31. Date filed (Month, Day, Year)	2004 32. Igistrar's	s Signature	and,				

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Dey Month Year **Physician** Mildred V. Maybury 21 2004 11 /Medical 12:05 P 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Moran Manor Nursing Home Alleg. Westernport If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 F Yrs. Director 212-09-5465 Usuel Residence of Decedent 3-22-1913 MD. nit. Peges 1 and 2 should be filed within 72 hours efter death with the Meryland different of Health end Mental Hygiene. orfant: if fem 27 is marked other than "natural", or items 23s or 28s-f ahow injury or other traumatic event, the Medical Experiment Per notified at injury or other traumatic event, the Medical Experiment Per notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No **Funeral Director** WV. Mineral Piedmont 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 95 E. ST. Hampshire 26750 USA 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Merried 2 Married 3altimore, Maryland 21215-0020 1□Yes 2□No Specify: Completed by 3 □ Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lloyd Atkins Grace Severs 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 288 Poplar Dr. Keyser, WV. 26726 James Maybury 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 3 ☐ Other (Specify) Scarpelli F.H. Crem. 11-24 Cresaptown 22. Name and Address of Fecility 21. Signeture of Funeral Service Licenses Fredlock Funeral Home -31 Jones St 23a. Pan1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Due to (or es e consequence of by Physician/Medical Examiner within 24 hours efter death. To the Funarei Director: After this certificate hes been signed by the ettending physician end completely filled in by the funeral director, page 2 should be deteched for use as the buriel-transit Hospital or Attending Physician: The law requires that the deeth certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence ol): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 2300 1. Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Sharsing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menger of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Naturel 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature end title of certifier 3 30. Neme and eddress of person who completed cause of death (Item 23e) (Type, Print)

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

NOV 2 4 2004

LAZ

ROSTBURG

32. Registrar's Signeture

		1 – For State Registrar	State of Marylar		artment of F				4 39280
Physic		Decedent's Name (First, Middle, Last, Helen Lucinda McKe					2. Date of De. Month		3. Time of Death
/Med Exami		4a. Facility Name (If not institution, give	street and number)			Location of Deat		4c. County of	Death
Funera Director		Frostburg Village Nursii 5. Social Security Number 6. Security Number		last birthday) Yrs.	If Under 1 Year Months Days	Frostburg If Under 24 Hrs. Hours Min.	8. Date of Bin (Month, Da		y Birthplace (State or Foreigr Country) Aaryland
		Usual Residence of Decedent  10a. State  10b. County  Maryland  Allegar	10c. Ci	ty, Town or Lo	ocation		Zomay		10d. Inside City Limits 1 □ Yes 2 📉 No
with the 7 3a or 28a-	I Director	10e. Street and Number 1749 Finz		tburg	10f. Zip Code			10g. Citizen of Wha	at Country?
5-0030 72 hours after death with the Maryland ineturet; or items 23a or 28a-f show dical Examinar must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hif Yes, specify Cuba	ispanic Origin? (S in, Mexican, Puert Specify:		- 14. Race - Black, \ Specify:	American Indian, White, etc.
within one.	Completed by	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired stress	during most of wor	king	16b. Kind of Busin	
al ylallu Z should be filed y and Mental Hygis marked other umatic event, II	To Be Co	17. Father's Name (First, Middle, Last) Harvey Caton				Sarah Bro	clothing factory  ame (First, Middle, Maiden Sumame)  DWN		
ic, Malyic s 1 and 2 should f Health and Mer item 27 is marke		19a. Informant's Name/Relationship (Ty Dale McKenzie  20a. Method of Disposition	SON 20b.	78 Arn	nstrong St.	Fros	ral Route Numbe tburg Date	Maryla Maryla 20c. Location - Cit	nd 21532-
partillor permit. Pages Department of Importent: If it any injury or o		1  Surial 2  Cremation 3  F  '4  Donation 5  Other (Specify)  21. Signature of Funeral Service Licens	Finze	l Cemete	matory or other place I'V  Name and Addre	29-1	Nov-2004 I	Finzel	Maryland
		23a. Pant. Enter the disease, or compl	Kury that caused the dea					rostburg, M	D 21532 Approximate
Physician /Medical but and physician and physician and physician and the prinal-transit	Ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) co	quence of):	monsay	- 5mb	oli3 im		Onset and Death 3 O Muins
The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 1 No 9 □ Unknown	3c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o	aldeath 3	∃Ectopic pregnancy ∃Other (specify)			23d. Date o	f delivery Day Year
requires that i	by	Part II. Other significant conditions con	ntributing to death but not res	sulting in the u	nderlying cause giv	en in Part I.			te to the cause of death?
: The law re cate has bee page 2 sho	Completed	Hypertensi	on Hy	odipe	demin			rmed? prior	e autopsy findings available to completion of cause of th? Yes 2□ No
ding Physician: Th. law requires th. After this certificate has been signe funeral director, page 2 should be	tlon; To Be	25. Was case referred to medical examiner? 1   Yes   2   No							
teat tor:	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, sti fy)			28f. Location (S City or Tow		r Rural Route Number,
To the Hospitel or Al within 24 hours after or To the Funerel Directompletely filled in by	edical	(Check only 2 Medical Exami	sician: To the best of my knoner: On the basis of examination and manner stated.	owledge, deat ation and/or in	vestigation, in my o	pinion, death occu	rred at the time, o	date and place, and	due to the cause(s)
4	Σ	29b. Signature and title of certifier			29c. Licens	-12 44	•	29d. Date signed (N	O H
nes		30. Name and address of person who con $Jesus Tan$ ,	M.D., 1070	m 23a) (Type,	Print) W Georg	es Cra	ek Rd. F	rostburg,	MD 2/532
St Regis	ate trar	31. Date filed (Month, Day, Year) NOV 2 9 2004	32. Registrar's Signi	ature	hoarks		,		

Wilma Maise

			1 _ State		epartment of Health and Certificate of Death		F2 63 41 4				
			Registrar  1. Decedent's Name (First, Middle, Last)		erinicale of Dealif	Reg.	2004	39282			
	Physici		Herbert Eugene	Norric	Ir		Day Year	0.00 4 44			
	/Medic Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of D		5, 2004 4c. County of De				
п			24605 Hollywood Road		Hollywood		Saint M	larvs			
	Funeral			ge (In yrs. last birthd	ay) If Under 1 Year If Under 24 I	Hrs. 8. Date of Birth (Month, Day, Ye		irthplace (State or Foreign Country)			
	Director		220-16-8901	81 Yrs	5.	December 3,		ryland			
	land		Usual Residence of Decedent           10a. State         10b. County	10c. City, Town or	r Location			10d. fnside City Limits			
	Mary Frsh	tor	Maryland Saint Marys	Holly	wood			1 ☐ Yes 2 🙀 No			
	h the	Director	10e. Street and Number	HOTTY	10f. Zip Code	10g.	Citizen of What C	Country?			
	th wit		24605 Hollywood Road		20636		USA				
	r dea	Funeral	11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.S. 1	<ol> <li>Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pt</li> </ol>	(Specify Yes or No- uerto Rican, etc.)	14. Race - Am Black, Wh				
36	s afte	by Fu	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ If Yes, Give Year or Dates:	No	1 ☐ Yes 2 ☒ No Specify:	, , , , , , , , , , , , , , , , , , , ,	Specific				
8	within 72 hours after death with the Maryland jiene. r then "neturel", or Items 23e or 28e-1 show the Madical Examirer must be notified at		3 Widowed 4 Divorced Year or Dates:  15. Decedent's Education	16a De	ecedent's Usual Occupation	166	Wn	ite			
21215-0036		Completed	(Specify only highest grade completed)	(G	ive kind of work done during most of e. DO NOT use retired)	working	. Kind of Busines:	symoustry			
212	filed within Hygiene. other then "	mo	Elementary/Secondary (0-12) College (1-4ors	·	ervice Manager	Ca	ar Dealers	hip			
멀	be filed ital Hygie od other event, II	Be	17. Father's Name (First, Middle, Last)		18. Mother's	Name (First, Middle, Maid	en Sumame)				
yla	2 should be and Mental Is marked ( eumetic ev	To	Herbert Eugene Norris, Sr.		Mary	Lucille Norris					
Maryland	2 sho		19a. Informant's Name/Relationship (Type, Print)	19b. Ma	ailing Address (Street and Number or	Rural Route Number, Cit	or Town, State,	Zip Code)			
	is 1 and 2 should be filed of Health and Mental Hyg item 27 Is marked other other treumetic event,		Ruth Emily Norris / Wife 20a Method of Disposition	246	605 Hollywood Road, H			7			
Baltimore,	Pages nent of h ant: If ite		1   Burial 2 □ Cremation 3 □ Removal from State	cemetery, c	crematory or other place)	December 200.	Location - City o	r Iown, State			
를	그는원들		' 4 ☐ Donation 5 ☐ Other (Specify)  21. Signa are 1 Funeral Service Usensee	Charles M	lemorial Gardens   8	. 2004 Le	onardtown	, Maryland			
æ	permi Dep Impo any I		Marka Hay Man. O.			Funeral Home, I	, A				
	_		Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650  23a. Part. Enter the disease, or complications that caused the teath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Ų	Physician		Immediate Cause (Finaf	-				Interval Between Onset and Death			
	/Medical		resulting in death)	a consequence of):				mms			
	Examiner		Sequentially list conditions h	Stage co	rdiorenailar d	sear		avenily.			
	p ==	Iner	cause. Enter Underlying	a consequence of)			0.				
	ificate be executed g physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events c	a consequence of):							
68760,	be es			a osnooquonos oi/.							
687		edlcal	d								
Вох	÷ 2, 10	n/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome		a D5		23d. Date of de	alivery			
	O O O	by Physician/M	in the past 12 months?  1 Yes 2 No  4 Pregnant at		3 □Ectopic pregnancy 5 □ Other (specify)		Month	Day Year			
P. O.	The law requires that the site has been signed by the bage 2 should be detache	hys	9 ☐ Unknown								
Ś	es th igned be de	by 6	Part II. Other significant conditions contributing to death b	ut not resulting in the	e underlying cause given in Part I.			o the cause of death?			
ord	requi	ted				_ 1 ∐ Yes	2∐No 3∐P	robably 4KUnknown			
Vital Record	The law cate has by page 2 s	Completed				24a. Was an autopsy	prior to	utopsy findings available completion of cause of			
a						performed?		s 2 No			
₹	sicien certii irecto	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ♣ No	ent 2□ER/Outpat	Other	Death Check onl one	. 50.				
o	g Phy er this eral d	$\vdash$	27. Manner of Death 28a. Date of Inju	ry 28b. Time	e of 28c. Injury at	g Home 5 Residence 28d. Describe how in		ecify)			
o	ath. r: Aftu	Certification:	1 Maturaf 5 ☐ Pending (Month, Da 2 ☐ Accident investigation	y Year) Injur	y Work? M 1 ☐ Yes 2 ☐ No						
Division	r Atte er de recto	tific	3 Suicide 6 Could not be determined 28e. Place of Inj building, et		street, factory, office	28f. Location (Street City or Town, Sta		ural Route Number,			
	itel o irs aff ral Di iled in	Cer	Stating, of	,-,-,-,,		2.1, 5. 7 51.11, 51.6	) F /				
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, to	Medical	29a. Certifier (Check only (Ch	f examination and/or	eath occurred at the time, date and pla r investigation, in my opinion, death oc	ace, and due to the cause courred at the time, date a	s) and manner and place, and du	s stated. e to the cause(s)			
	thin 2 thin 2 the implet	Med	one) and manner sta	ited.	29c. License number		Date signed (Mont	, ,			
	± ₹ 5			CM -	0 47 59	2	- 1	, Jay, 18a1)			
/.	M		30. Name and address of person who completed cause of d			1.	2-709				
0	. ,		! /		, P.O. Box 664, Leona	rdtown, Marvlan	d 20650				
	Sta	te	31. Date filed (Month, Day, Year) 32. Registr.	ar's Signature		,,					
	Registr	ar	DEC 0 7 2004	man 1 1 1	Branks						

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of rtificate of			2004	39283
	Physici	ian	Decedent's Name (First, Middle, I	ast)				2. Date of Death Month	Day Year	3. Time of Death
	/Media	cal	Griffith S. Ours  4a. Facility Name (If not institution, g			4b. City. Town.	or Location of Dea	November	r 23, 2004 4c. County of Death	
1	Examir	ier	215 Lore Road			Solom			Calvert C	
	Funeral			Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs	(Month, Day, Y	9. Birth	place (State or Foreign ntry)
	Director		292-16-8640 Usual Residence of Decedent	A.W. Z.J.	87 Yrs.			August 2	0, 1917 M	aryland
	ryland how		10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits
	8a-1 s	octo	MD Calv	ert	Solomo					1 ☐ Yes 2 XNo
	72 hours after death with the Maryland naturel', or items 23e or 28a-1 show direal Examinat must be notified at	Funeral Director	10e. Street and Number 215 Lore Road			10f. Zip Code	688	10g	i. Citizen of What Cou USA	ntry?
	death ms 23	neral	11. Marital Status	12. Was Decedent	Ever in U.S. 13.		Hispanic Origin? (5 ban, Mexican, Puer	Specify Yes or No-	14. Race - Ameri	
9	or Ite		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give	No	If Yes, specify Cull  1 ☐ Yes 2 ☑ No		to Hican, etc.)	Black, White Specify: Wh	ite
21215-0036	hours turel',	Completed by	3X Widowed 4 □ Divorced	Year or Dates:				10		
-51	n "nat	piete	15. Decedent's (Specify only highest of	rade completed)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of wa	rking	b. Kind of Business/Ir	idustry
212	filed within Hygiene. Ither than "	Com	Elementary/Secondary (0-12)	College (1-4or	Fa	rmer			Own Farm	
	be file ital Hy id oth event	Be	17. Father's Name (First, Middle, La					me (First, Middle, Ma		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Importent: if item 27 is marked other than "naturel", or items 23e or 28a-1 show any injury or other treumatic event, the Medical Examination usit be notified at once.	To	Griffith S. Ou		10h Maili	na Addrona (Stron	Edith			rnow
Ma			Nancy Maynard			Dunkirk		wings, MD	City or Town, State, Zi, $20736$	Code)
ē,		- 70	20a. Method of Disposition		20b. Place of Dispo				c. Location - City or T	own, State
imo			1 ☐ Burial 2 ☐ Cremation 3 1 ☐ Cremation 3 ☐ Other (Special Control of Cont			ction Ce			Clinton, M	D
Baltimore,	permit. Departr Importe any inji		21. Signature of Juneral Service Lic	~	2:	2. Name and Addr	ess of Facility I	ee Funera	l Home Cal	vert, PA
	70 = 4 O		23a. Part1. Enter the disease, or co						. Owings,	MD 20736 Approximate
	Physician /Medical Examiner	iner	shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. CHRON  Due to (or as	a consequence of):	euctn	) E (u,	NG D158	ASE	Interval Between Onset and Death YEARS
8760,	cate be executed oblysician and the burial-transit	dicai Examiner	that initiated events resulting in death) Last	c	a consequence of):					
O. Box 6	The faw requires that the death certificate be executed tile has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant al 9 Unknown	2 Fetal death 3	☐Ectopic pregnand ☐ Other (specify)	гу		23d. Date of deliv Month	ery Day Year
Records, P.	quires that n signed b	Completed by Pl	Part II. Other significant conditions HYPER TENSION		ut not resulting in the u	nderlying cause g	ven in Part I.		co use contribute to t	
Ö	law requir as been si 2 should l	piete						24a. Was an	24b. Were auto	ppsy findings available
R		mo:						autopsy performer	d? death?	mpletion of cause of 2□ No
of Vital	Physician: The lav this certificate has al director, page 2	Be C	25. Was case referred to medical examiner?					ath (Check only one)		
of	Physi this c al dire	P.	1 ☐ Yes 2 ☑ No	Hospital:		IL SELDOA	P I.A.		e 6 Other (Special	y)
on	ding F h. After funera	tion	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date of Inju (Month, Da	ry Year) 28b. Time o	Wo	ork? ⊇Yes 2 □ No	28d. Describe how	injury occurred	
Division	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Certification:	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of Inj	ury - At home, farm, str c. (Specify)			28f. Location (Stree City or Town, S	et and Number or Rure State)	al Route Number,
	To the Hospitel within 24 hours a To the Funerel Completely filled	edicai (	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best aminer: On the basis o and manner st	f examination and/or in	n occurred at the t vestigation, in my	ime, date and place opinion, death occu	and due to the caus irred at the time, date	e(s) and manner as s and place, and due to	tated. o the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier			29c. Licen	se number	29d.	Date signed (Month,	Day, Year)
•			Pau 1	M		D40	0370		November 2	4, 2004
	15		30. Name and address of person where Peter Wisniewski		leath (Item 23a) (Type. 845 Town C		vd. Dunk	irk. Marv	land 20754	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registr	s Signature	4		TILLY	20101	
	Registi	- 1	NOV 2	2 4 2004 ▶ €	Voque H.	Smarke	,			

			partment of Health and Mertificate of Death	Mental Hygie	- 6 11111	39284
		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Yeer	3. Time of Death
Physici /Medic		Ben Norman Powell		December	•	12:30 PM
Examin		4e. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dee	th
		St. Mary's Hospital	Leonardtown		St. Mar	*
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 260-90-5239 53 Yrs.	y) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yo	ear) C	thplace (State or Foreign ountry)
Director		260-90-5239 ASIM ZUF 53 Yrs.		Nov. 3,	1951   Ge	orgia
yland		10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
Mar S-f.st	tor	Maryland St. Mary's Callaw	ay			1 ☐ Yes 2X No
death with the Maryland rms 23a or 28s-f show frougt be notified at	Directo	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Co	ountry?
23a		45025 Three Way Lane	20620		U.S.A.	
er dez	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto</li> </ol>	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
S afte	by F	1 □ Never Married 2 Married 1 M Yes 2 □ No 1975 — If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates: 1995	1 ☐ Yes ANO Specify:		Specify:	
Z I D-UUSO thin 72 hours af e. an "natural", or Medical Exam		1777	edent's Usual Occupation	161	b. Kind of Business	hite Modustov
n na na na na na na na na na na na na na	Completed	(Specify only highest grade completed) (Gi	ve kind of work done during most of work . DO NOT use retired)	king	o. King of Eganlesa	middatty
d with	E	Elementary/Secondary (0-12) College (1-4or 5+) 3 Av	iation Mechanic		U.S. Nav	V
e file other	ВеС	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Mai	iden Sumame)	
Viano vuld be fill Mental Hi arked oth	ToE	Glen Powell	Winona	Norman		
DESILITIONE, MISTYISTIC Z I Z I D-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Supportent: If item 27 is marked other than "natural; or Items 23a or 28s-1 show any injury or other traumatic event, the Medical Examiner or at the notified at ODCE.		19a. Informant's Name/Relationship (Type, Print)	iling Address (Street and Number or Rui	ral Route Number, C	ity or Town, State,	Zip Code)
e, M 1 and 2 Health Em 27 ther tr			5 Three Way Lane C			
OTO 985 1 of H H iten		20a. Method of Disposition  1	position (Name of rematory or other place)	Date 200	c. Location - City or	Town, State
Saltimor Sermit. Pages Department of I mportent: If its iny injury or o		`4 □Donation 5 □Other (Specify)	Mem. Gardens 12-9		onardtown	n, Maryland
Dan permit Depar Import any in once.		21. Signature of Funeral Service Licenture	22. Name and Address of Facility Br	insfield l	Funeral H	ome, P.A.
00560	1-1-1		22955 Hollywood Ro			
		23a. Part1. Enter the disease, or complications that caused the death. Do not eshock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)  Dissecting Thor	acic / Abdominal A	neurysm		24 Hours
/Medical Examiner		Due to (or as a consequence of):				
* 8	_	Sequentially list conditions, if any, leading to immediate  B. Hypertension  Due to (or as a consequence of):				10 Years
ted nsit	Examiner	Cause (Disease or injury Smolzing				25 Years
execu	xai	that initiated events resulting in death) Last c. Due to (or as a consequence of):				25 lears
The law requires that the death certificate be executed.  The law requires that the death certificate be executed ate has been signed by the attending physicien and cage 2 should be detached for use as the burial-transit						
g phy as th	ed					
w requires that the death certific we seem signed by the attending planduld be detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death	DEctopic pregnancy		23d. Date of de	ivery
deat deatt	sicie	1 Yes 2 No	Other (specify)		Month	Day Year
at the	hy	9 🗆 Onknown				
igned be de	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	11		the cause of death?
w requires been sign should be	ted			XIX Yes	2UN0 3UP	obably 4 Unknown
law las b	ompleted			24a. Was an autopsy	prior to	topsy findings available completion of cause of
The Table Page	Co			performed 1 ☐ Yes <b>2</b> 0		2 <b>X</b> No
VICAL DEC sicien: The law s certificate has b lirector, page 2 s	Be	25. Was case referred to medical examiner?	0.1	h (Check only one)		
Physicien: Physicien: This certificater, ral director,	٦.	1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpate  27. Manner of Death 28a. Date of Injury 28b. Time		ome 5 Residence		cify)
ding After fune	ertification:	Natural 5 Pending (Month, Day Year) Injury		Zad. Describe flow i	njury occurred	
deat deat ctor: y the	fica	3 Suicide 6 Could not be 28e. Place of Injury : At home, farm.		28f. Location (Stree	t and Number or Ri	ural Route Number
after Dire	erti	4 Homicide determined building, etc. (Specify)	most, ractory, critical	City or Town, S		
spite nours nerel	alc	29a. Certifying Physician: To the bespot my knowledge, de	ath occurred at the time, date and place,	and due to the caus	e(s) and manner as	stated.
To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page	edical	(Check only 2 Medical Examiner: On the basis of examination and/or one)	investigation, in my opinion, death occur	red at the time, date	and place, and due	to the cause(s)
To the within To the comp	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Mont	h, Day, Year)
20		C/NOW (COSC)	052196	)	2-6-0	4
2		30. Name and address of person who completed cause of death (Item 23a) (Typ John Scott Tibball MD, 2054 WILD	e. Print) ENDOD CENTER, Calif	GRNIA. N.	10 20	619
Sta Registr		31. Date filed (Month, Day, Year) 32. Registar's Signature	29c. License number  D 5 2196  a. Print)  EUROD CENTER, CZ/19			

Registrar

State of Maryland / Department of Health and Mental Hygiene 00 L 39286 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day **Physician** 10,50A M per 28 100c John D. Peters /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4873 Telegraph Road E1kton Cecil If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□ F Months Yrs. Director 543-14-2130 FEB 28, 0regon Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits itam 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Medical Expedient retrinal ke redified at 1 Yes 2 No Director Cecil Maryland Elkton 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4873 Telegraph Road 21921 United States Funeral death 12. Was Decedent Ever in U.S. Armed Forces? World 1 ∑Yes 2 □ No If Yes, Give Year or Dates: War II Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 2 should be filed within 72 hours after of and Mental Hygiene.
Is marked other than "natural", or Ital 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Boiler Operator Chemical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Peters Catherine Hildebrand 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: if itam 27 is rr any injury or other traum 2005. Dortha M. Peters/Wife 4873 Telegraph Road, Elkton, Maryland 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State November 1 ☐ Burial 2 【ACremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 29, 2004 Lawn Croft Crematory Linwood, Pennsylvania 21. Signature of Funeral Service Licensee Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 Approximate Interval Between Onset and Death 3 Morrile ( 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Lung Cource disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of): attending physician for use as the burial Box 68760. 99 Physician/Medical IF FEMALE If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy perform 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 🔊 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred a Hospital or Attanding P. 24 hours after death. 9 Funeral Diractor: After t Certification: Injury 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1🔯 Certifying Physician: To the best of my knowledge, death occurred at the fime, date and place, and due to the cause(s) and manner as stated. To the Hos within 24 ho To the Fun completely i 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier Mes a 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 Chesap whe for pice, Elkton up Northern Fur Kos scason 5 31. Date filed (Month, Day, Year) State NOV 2 9 2004 Registrar

			1- State of Maryland / Department of Health and Mental Hygierre O 1 State of Maryland / Department of Health and Mental Hygierre O 1 State of Maryland / Department of Health and Mental Hygierre O 1 State of Maryland / Department of Health and Mental Hygierre O 1 State of Maryland / Department of Health and Mental Hygierre O 1 State of Maryland / Department of Health and Mental Hygierre O 1 State of Maryland / Department of Health and Mental Hygierre O 1 State of Maryland / Department of Health and Mental Hygierre O 1 State of Maryland / Department of Health and Mental Hygierre O 1 State of Maryland / Department of Health and Mental Hygierre O 1 State of Maryland / Department of Health and Mental Hygierre O 1 State of Maryland / Department of Health and Mental Hygierre O 1 State of Maryland / Department of Health and Mental Hygierre O 1 State of Maryland / Department of Health and Mental Hygierre O 1 State of Maryland / Department of Health and Mental Hygierre O 1 State of Maryland / Department of Health And Mental Hygierre O 1 State of Maryland / Department of Health And Mental Hygierre O 1 State of Maryland / Department of Health And Mental Hygierre O 1 State of Maryland / Department of Health And Mental Hygierre O 1 State of Maryland / Department of Health And Mental Hygierre O 1 State of Maryland / Department of Health And Mental Hygierre O 1 State of Maryland / Department of Health And Mental Hygierre O 1 State of Maryland / Department of Health And Mental Hygierre O 1 State of Maryland / Department of Health And Mental Hygierre O 1 State of Maryland / Department of Health And Mental Hygierre O 1 State of Maryland / Department of Health And Mental Hygierre O 1 State of Maryland / Department of Health And Mental Hygierre O 1 State of Maryland / Department / Departme	287
	Physici /Medi		Tulia Frances Miles Poole Month Day Year 800	ne of Death
	Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death  4d. County of Death	
	Director		Usual Residence of Decedent	
	ne Maryla 8a-f shor	ector		Yes 2X No
	with ti	늅	106. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10826 Brentwood Terrace 21740	
036	s 1 and 2 should be filed within 72 hours after death with the Maryland [Health and Mental Hygiene. Itam 27 is marked other than "natural", or Itama 23a or 28a-f show other traumatic event, the Medical Evertiner must be inclified at	by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces? 1   Never Married   2   Married   3   Wildowed   4   Divorced   4   Divorced   4   Divorced   5   Married	n,
21215-0036	within 72 ho ene. then "natur the Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Technician  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16c. Do NOT use retired  Technician	
Maryland 2	should be filed ind Mental Hygis s marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)  Mary Angeline Ward	
Jar	2 sho and is mu		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	J 21740
Baltimore, I	Pages 1 and 3 ent of Health nt: If itam 27 y or other tr		W. Jan Poole (Son)  10826 Brentwood Terrace Hagerstown Marylan  20a. Method of Disposition  1 CXBurial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  10826 Brentwood Terrace Hagerstown Marylan  20b. Place of Disposition (Name of cemetery, crematory or other place)  St. Pauls Cemetery  Dec. 1, 04  Clear Spring Ma	te
Balti	permit. Pages: Department of P Important: If its any injury or of		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Douglas A. Fiery Funeral  1331 Fastern Blvd. N. Hagerstown Maryland  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approx.	Home 21742
8760,	law requires that the death certificate be executed as been signed by the attending physician and as been signed by the attending physician and as been signed by the attending physician and as been signed by the attending physician and as a second of the principle.	lical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or infury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	Between and Death
.O. Box 6	at the death certifica by the attending ph stached for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Year
Ф	w requires that t been signed by should be deta	by	Part it. Other significant continuous continuous to the cause of the cause given in Part.	
Vital Records,	The ate h page	Completed	24a. Was an autopsy finding performed performe	ngs available of cause of
<u>₹</u>	Physician: Th rthis certificate ral director, pag	o Be	examiner? Char	
ion of	After	$\vdash$		
Division	tal or Attandisations at Director: Aed in by the fi	Certification;	3 Suicide 4 Homicide  3 Suicide 4 Homicide  3 Suicide 4 Homicide  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Incided City or Town, State)	Vumber,
	To the Hospital or At within 24 hours after of To the Funeral Dirac completely filled in by	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated.	
)	To To con	2	D 62223 11-29-04	u /
6H	15		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  D. Balanu 340 mill H. Hr. Md 21740	
	Sta Registi		31. Date filed (Month Pay, Year). 2004 32. Begistrar's Signature	

## amend 24a per Dr. g839 1/20/ 05 KBH Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryla	and / Depa <i>Cer</i>	irtment of H	lealth and I Death		jien (e () (leg. No.	39288
	Physici /Medic	_	1. Decedent's Name (First, Middle, L Tsacc	ast)	Pe	rez		2. Date of Dea Month	Day	2004 3. Time of Death
	Examin	er		Bayview	and the set of a set	_ 1/3	r Location of Deat			imore City
	Funeral Director		N/A	Sex 7. Age (In y	vrs. last birthday) Yrs.	Months Days	Hours Min.		r, Year)	9. Birthplace (State of Foreign Country)  Maryland
	B Maryland Be-f show	ctor	Usual Residence of Decedent		City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 No
	with the	i Director	10e. Street and Number 400 Old Virgin	in Road		10f. Zip Code 2182	1		10g. Citizen of US	What Country?
336	within 72 hours after death with the Maryland ene. then "natural", or itams 23e or 28e-f show the Madical Examana. Just be indiffed at	by Funerai	11. Marital Status  12. Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever i Armed Forces?				Specify Yes or No- to Rican, etc.)		ce - American Indian, ick, White, etc.
21215-0036	within 72 hor lene. then "natura the Medical E	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)		(Give	lent's Usual Occup kind of work done OO NOT use retired	ation during most of wo		16b. Kind of E	Business/Industry
pu	be filad ital Hyg id other event,	Be	17. Father's Name (First, Middle, Las	st)				me (First, Middle,		
Maryland	permit. Pages 1 and 2 should be filad within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or itams 23e or 28e-1 show any injury or other treumatic event, the Medical Examination ust be notified at once.	၉	Juan Manuel Casi 19a. Informant's Name/Relationship		19b. Mailir	ng Address (Street		Perez	r, City or Town	, State, Zip Code)
nore, M			Laura Perez/Moth  20a. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Other (Spec	☐Removal from State	b. Place of Dispo cemetery, crer	old Vir sition (Name of natory or other place y Cremat	CB)	Date	20c. Location	ity, Nu 21851 -City or Town, State 1ry, Maryland
Baltimore,	permit. P Departme Importen any injury	(	1. Signature of Funeral Service Lic	ensee	295 1.1	Name and Addre	ss of Facility eral Hom	ie nue. Pri	ncess A	Anne, MD 21853
	Pnysician /Medical		Ma. Part1. Enter the disease, or co shock, or heart failure. List on immediate Cause (Final disease or condition resulting in death)	a. Shock	death. Do not ent	er the mode of dyin	g, such as cardia	correspiratory an	rest,	Approximate Interval Between On et and Death
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		inateo	Intra	verscula	/ Coas	ulaF	2 day
8760,	death certificate be executed e attending physicien and ed for use as the buriat-transit	dicai Examin	Cause (Disease or injury that initiated events resulting in death) Last	c. Tresum Due to (or as a con Extren	sequence of):	remate	rity	(290	uk)	loday
.O. Box 68	ne death certifi the attending I thed for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 Live birth 2 1 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnancy	1			ate of delivery onth Day Year
Ω.	The law raquiras that the tage has been signed by bage 2 should be detact	by	Part II. Other significant conditions Intraute		1 -1	nderlying cause giv		23e. Did to	_1	atribute to the cause of death?  3 Probably 4 Unknown
al Records,		Completed						1 ☐ Yes	sy med? 2. No	Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No
of Vital	ysician iis certif director	To Be	25. Was case referred to medical examiner?  1  Yes 2	Hospital: 1 Impatient	2 ER/Outpatier	nt 3□ DOA Oth	000	ath <i>(Check only o</i> Home 5 Resid		her (Specify)
		atlon:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date of Injury (Month, Day Yea	28b. Time o	Wor	ryat rk?  Yes 2 ⊟No	28d. Describe h	ow injury occu	rred
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not determine		At home, farm, str pecify)	eet, factory, office		28f. Location (S City or Tow		ber or Rural Route Number,
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical (	29a. Certifier 1 Certifying (Check only one)	Physician: To the best of my aminer: On the basis of exar and manner stated.	knowledge, deat mination and/or in	h occurred at the tir vestigation, in my o	ne, date and place pinion, death occ	e, and due to the curred at the time, o	cause(s) and m date and place,	nanner as stated. , and due to the cause(s)
)	To the within To the comp	W	29b. Signature and le of criffier	300 Neon	atologi	29c. Licens 543	e number		NoV	ed (Month, Day, Year) 21, 200 4
			30. Name and address of person where the same and address of person where the same and the same	no completed cause of death 4940	(Item 23a) (The,	Print) (n Alle	Balt	inoce u	n) Z	1224
	Sta Regist	ate	31. Date filed (Month, Day, Year)  NOV 2	32. Registar's S	Signature &					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Phillip Wayne RYAN 200 2:34 November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 25, 1 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F Months Days Hours Yrs. 1940 Director 220-40-2344 63 Indiana Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location or 28a-f show r then "netural", or items 23e or 28a-f shoving Medical Examera rulet be notified at 1 ☐ Yes 2 X No Director Williamsport Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21795 10846 Archer Lane USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 MNo If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 0 delivery retail home products 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth eny injury or other traumatic event 9DRB. Be Edith Marie Bennett James Elza Earl Ryan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Ryan - wife 10846 Archer Lane, Williamsport, Md. 21795 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Lawn Mem. Park 12/4/04 Hagerstown, Maryland A □ Donation 5 □ Other (Specify) 21. Signal of Funeral Service Licer 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Je41515 /Medical Due to (dr as a consequence of): Examiner 147h0315 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a con equence of) Box 68760, Completed by Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year be detached for 5 Other (specify) 4 Pregnant at time of death Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Monknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 TNo 1 Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Mo Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27 Manner of Death After 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No after death. investigation 2 Accident the 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide To the Hospitel within 24 hours a To the Funeral Completely filled in Hospitel 29a. Certifier 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 20060394 12/01/04 DH-15 Hagerstown Maryland 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ar Murshed II 26 Opal Cod Court Murshed Opal 31. Date filed (Month Pay Year) 32. Registrar's Signature State Registrar

			State of Maryland / Dep	partment of Health and M	-	•
			1 - State Registrar Co	ertificate of Death		1N2004 39290
	Physici	an a	1. Decedent's Name (First, Middle, Last)		<ol><li>Date of Death Month</li></ol>	Day Year 3. Time of Death
	/Medic		John Thomas Rogers		November	27, 2004 1:30 P.M
	Examin	er	4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
	Former		45455 St. George's Avenue  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Piney Point  (1) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	St. Mary's  9. Birthplace (State or Foreign
	Funeral Director		073-05-0227 18 M 2□F 88 Yrs.	Months Days Hours Min.	(Month, Day, ) Oct. 27	(ear) 9. Birthplace (State or Foreign Country) New York
	p _		Usual Residence of Decedent			
	show	_	10a. State 10b. County 10c. City, Town or			10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	the M	ecto	MD St. Mary's Pine	ey Point	100	g. Citizen of What Country?
	with a or	Dir	45455 St. George's Avenue	20674		
	ns 23	era		Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto		Jnited States  14. Race - American Indian,
9	or Ite	F	1 Never Married 2 Married   Armed Forces? 1 Myes 2 No WWII	If Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2 ☒ No Specify:	Rican, etc.)	Black, White, etc.  Specify: White
93	ural',	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:			
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show ta Medical Exerciter must be notified at	Completed by Funeral Director	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Given its	edent's Usual Occupation re kind of work done during most of work! . DO NOT use retired)	ng 16	6b. Kind of Business/Industry
12	within ene. than	omo	Elementary/Secondary (0-12) College (1-4or 5+)	efighter		Fire & Rescue
d	illed Hygin other	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Ma	
<u>lar</u>	uld be Aenta rked tic ev	To B	Norman Rogers	Jenn	ie Reid	
Maryland	iges 1 and 2 should be filed within 72 hours atler death with the Marylan It of Health and Mental Hygiene. If item 27 Is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, If a Medical Examiner must be notified at			iling Address (Street and Number or Rura		
≥,	and ealth m 27 her tr			5 St. George's Aver		
Baltimore,	ges 1 it of H if ite or otl		E Buriar 2 Micremation 3 Deemovariion State	•	9,2004	Oc. Location - City or Town, State
ij	permit. Pa Departmen Important: any injury			21d-Echols Cremator		harlotte Hall, MD
Ba	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra once.			22. Name and Address of Facility Bri		town, Maryland 20650
			23a. Part1. Enter the disease, or com, to floor that diuse the death. Do not e shock, or heart failure. List only in cos se on the cost.	nter the mode of dying, such as cardiac	or respiratory arres	t, Approximate Interval Between
	Physician		snock, or neart failure. List only in a cause on lime.  Immediate Cause (Final	Cardianastha		Onset and Death
	/Medical		disease or condition resulting in death)  Due to (or as a consequence of):	Artery Discase		
	Examiner		Sequentially list conditions.	Artery Discuse		
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
	ate be executed hysician and he burial-transit	Examiner	that initiated events c			
760,	e be e	calE	d			
89	tificating phy					
Вох	th cer tendir r use	an/N	IF FEMALE: 23b. Was decedent pregnant 1	□Ectopic pregnancy		23d. Date of delivery
	e dea the at ned fo	Physician/Med	in the past 12 months?  1   Yes 2   No 9   Unknown 9   Unknown	Other (specify)		Month Day Year
P.0	The law requires that the death certifical te has been signed by the attending phyage 2 should be detached for use as the	Phy	Part II. Dther significant conditions contributing to death but not resulting in the	underlying cause given in Part I	23e. Did toba	cco use contribute to the cause of death?
Records,	w requires that s been signed b should be deta	d by	g		1 ☐ Yes	2 No 3 ☐ Probably 4 ☐ Unknown
COL	w requestions	lete			24a. Was an	24b. Were autopsy findings available
Re	hysician: The law his certificate has t I director, page 2 s	Completed			autopsy	prior to completion of cause of death?
ta		0	25. Was case referred to medical	26. Place of Death	1 Yes 2	No 1 Yes 2 No
Į V	Physician: rthis certific ral director,	To B	examiner? 1   Yes   2   No   Hospital: 1   Inpatient   2   ER/Outpati	ent 3 DOA Other: 4 Nursing Ho	me 5 Residen	ce 6 ☐Other (Specify)
D 0	ing Pl	on:	27. Manner of Death 1	Work?	28d. Describe how	injury occurred
sio	tendi Jeath. tor: A the fu	catl	2 Accident investigation	M 1 Yes 2 No	206 Leasting (Ctus	at and Number or Duri Deuts Number
Division of Vital	after d Direc	Certification;	4 Homicide  determined  28e. Place of thjury - At home, farm, building, etc. (Specify)	street, ractory, office	City or Town,	et and Number or Rural Route Number, State)
	To the Hospital or Attending Physical within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral director.	al C	29a. Certifier Certifying Physician: To the best of my knowledge, de	ath occurred at the time, date and place,	and due to the cau	se(s) and manner as stated.
	n 24 h	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurr	ed at the time, date	e and place, and due to the cause(s)
	To the comp	Ž	29b. Signature and title of certifier	29c. License number	290	I. Date signed (Month, Day, Year)
•	NA		· Ay & le vo	17610		November 29, 2004
	9 10		30. Name and address of person who completed cause of death (Item 23a) (Typ		. Ti 1	(al. MD 20679
	Sta	te.	David J. Tardio, M.D. 110 Hospit  31. Date filed (Month, Day, Year)  32. Registar's Signature	4	e rrederi	ICK, MD 200/8
	Regist		NOV 3 0 2004 > Marca M	Goselle		

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Ng. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Nov 23 2004 **Physician** 1520 Edward Reuter /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince Frederick Calvert Calvert Memorial Hospital 7. Age (In yrs. last birthday) R9 Yrs. | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. | Aug 26 1915 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1**⊋**M 2□F Illinois Director 320 09 6407 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f shov traumatic event, the Madical Examinar must be notified at Calvert Lusby Maryland 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20657 United States 280 Elkins Lane 23a Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Ø Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married white 43-46 ö 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) NUS at Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) power plant construction electrical engineer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Nicholas Reuter Pages 1 and 2 should be fil tment of Health and Mental H tant: If item 27 is marked otl Katherine Bowler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 280 Elkins Lane Lusby, MD 20657 19a. Informant's Name/Relationship (Type, Print) Mary C Reuter- wife othar 20b. Place of Disposition (Name of cemetery, crematory or other plathov 27 Our Lady Star of the Sea 20a. Method of Disposition → Burial 2 □ Cremation 3 □ Removal from State 20c. Location - City or Town, State ö Solomons Maryland Department of Important: If any Injury or once. `4 ☐ Donation 5 ☐ Other (Specify) use of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20676 Approximate Interval Between Onset and Death Immediate Cause (Final HORTIC **Physician** STENOSIS years SEVERE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine use as the burial-transit Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No jo 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. DIVERTICULOSIS PNEUMONIA 1 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 3 NO 1 Yes certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Yes 2 N his 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident

The law requires that the death certificate be executed Box 68760, P.0. Records, Division of Vital Hospital or Attending Physician: Certification: death. Director; 24 hours a Medicai

with the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0036

6 Could not be 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29c. License number D36969

MD

20657

29d. Date signed (Month, Day, Year) 11124104

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SCARIA MATHEW MD PO BOX (789. LUSBY

31. Date filed (Month, Day, Year) 32. Registras Signature 2004

State

Registrar

within 2 To the

2

		1	For State Registrar Amended#18pe	State of Maryland		rtment of F			ne 2.004	39292	
	Dhuaiaic		1. Decedent's Name (First, Middle, Last)					2. Date of Death	Day Year	3. Time of Death	
	Physicia /Medic	al -	Kaye Eliza  4a. Facility Name (If not institution, give str		amsbur	g 4b. City, Town, o	or Location of De	November	4c. County of Dea	7:15PM M	
	Examin	er	Kline Hospice Hous			Mt. Ai			Frederic		
	Funeral Director		217 30 1713	7. Age (In yrs. I	a <i>st birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M		ear) Co	thplace (State or Foreign buntry) ryland	
	yland Now		Usual Residence of Decedent  10a. State 10b. County		, Town or Loc					10d. Inside City Limits	
	e Man Sa-f sh	Director	Maryland Frederic	c F	rederi					1 <b>X</b> Yes 2 ☐ No	
	a or 24		10e. Street and Number	1		10f. Zip Code 21702	,		Citizen of What Co	ountry?	
	death ms 23	Funeral	1824 Millstream Dr:	. Was Decedent Ever in U. Armed Forces?	S. 13. V			(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, Whit		
920	72 hours after death with the Maryland 'neturel', or Items 23a or 28a-1 show digal Exertation must be notified at	þ	1 ★Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:		Yes 2 1 No	Specify:	ono mean, etc.)	Specify: Wh:		
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. item 27 is marked other then "neturel", or Items 23a or 28a-f show other treumatic event, I'te M. dical Exam or it ust be notified at	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)		(Give	ent's Usual Occup kind of work done OO NOT use retire	during most of v	vorking	b. Kind of Business/Industry		
7	e filed wi		17. Father's Name (First, Middle, Last)	5+	Tea	cher	18. Mother's N		Public Ed		
land	ould be f Mental I arked of	To Be		amsburg			Mary <del>Mary</del>	lame (First, Middle Mail 7 Alice Elea - Alice Ma	anor Mart <del>irtz</del>	Z	
Maryland	nd 2 should be Ith and Mental 27 is marked of r treumatic ev		19a Informant's Name/Relationship (Type Mary Alice M. Rams Hary A. Ramsburg/H.	sburg/Mother				Rural Route Number, C			
ore,	es 1 and 2 of Health I item 27 i		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Re	20b. P	lace of Dispos emetery, cren	sition (Name of natory or other pla	сө)	Date 20d	c. Location - City or	Town, State	
Baltimore,	Pag tment tent: f		* 4 □ Donation 5 □ Other (Specify)	G1a	de Cen			27/2004 Wa			
Bai	permit. Pages: Department of the Importent: If ite eny injury or of once.		21. Signature of Funeral Service Licenses	ta Blon				tauffer Fur Pike, Frede			
	-		23a. Part: Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final		n. Do not ente	er the mode of dyi	ng, such as card	liac or respiratory arrest,		Approximate Interval Between Onset and Death	
	Pnysician /Medical		disease or condition resulting in death)	Due to (or as a consequence	ARD (	Lung C	Chemi	a		MEUNS	
П	Examiner		Sequentially list conditions, b.	Metast		Lung C	ances			months.	
	ted nsit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	terice of).						
o,	be executed sician and burial-transit		that initiated events c. resulting in death) Last	Due to (or as a consequ	tence of):					-	
8760	cate be ohysicii the bu	dical	d.								
Box 6	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the buriat-transit	Physician/Me	in the past 12 months?  1 \( \subseteq \text{Yes}  2 \subseteq \text{No} \)	c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do	death 3	Ectopic pregnand Other (specify)	у		23d. Date of de Month	livery Day Year	
P.0	that the de ned by the a		9 ☐ Unknown  Part II. Other significant conditions cont		ulting in the ur	nderlying cause o	ven in Part I.	23e. Did tobac	co use contribute to	o the cause of death?	
ds,	uires t signe Ild be c	3	Cance	0 1	_				2 □ No 3 □ P		
of Vital Records,	e _ c	Completed						24a. Was an autopsy performes	d? prior to death?	utopsy findings available completion of cause of	
ital	i <b>cien</b> : Th certificate rector, pag	Be Co	25. Was case referred to medical				26. Place of I	1 ☐ Yes 2 Death (Check only one)	No 1 ☐ Yes	; 2 □ No	
of V	Physicien: r this certific ral director,	은	T Tes 25 140	The state of the s	ER/Outpatien	1 3 DOA		g Home 5 Residence		holly) HOSPICE HOLE	
ono	ding Filh. After funer	tlon:	27. Manner of Death  1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo	rk? ]Yes 2 □ No	20d. Describe flow	injury occurred		
Division	ol or Attendin safter death. I Director: Af d in by the fur	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str	eet, factory, office		28f. Location (Stree City or Town, S		ural Route Number,	
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical C	29a. Certifier (Check only) (Ch	cian: To the best of my kno er: On the basis of examina and manner stated.	wledge, death tion and/or inv	n occurred at the t vestigation, in my	ime, date and pla opinion, death o	ace, and due to the caus courred at the time, date	se(s) and manner as and place, and due	s stated. e to the cause(s)	
)	To the within To the compl	Me	29b. Squature and title of certifier  A-Z-HE	SAR MO		29c. Licen	se number f 4 ( 6 4	+	Date signed (Mont	_04	
	8+15		30. Name and address of person who cor	npleted cause of death (Item			10 217	702 A	2 HEGH	421	
	Sta Registr		31. Date filed (Month, Day Year) 2 9	2004 Sens	iture	b 1	parks				

			For State Registrar	State of Marylan		artment of H			iene 004	39293
T	Observatad		1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month	h Day Year	3. Time of Death
	Physici /Medio		Douglas Br	uce Stewart				Novembe	r 29, 200	4 7:13 A M
	Examir	ner	4a. Fecility Name (If not institution, give s	street and number)		4b. City, Town, or	Location of Deat	h	4c. County of Dea	ath
			22453 St. Clements Ave 5. Social Security Number 6. Sex		last hirthday	Compton If Under 1 Year	If Under 24 Hrs	P. Data of Birth	Saint Mary	
	Funeral Director			/ Age (#/ y/s.	53 Yrs.	Months Days	Hours Min.			rthplace (State or Foreign Country)
			Usual Residence of Decedent				<u> </u>	May 13, 1	. Fel	nnsylvania
	how		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	86-1 s	cto	Florida Indian Riv	er Se	bastian					1 ☐ Yes 2XXNo
	vith th	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	country?
	s 23s	erai	432 Tulip Road	12. Was Decedent Ever in U	6 12 1	32958	icagain Origin? (S	Pacify Vos at No	USA 14. Race - Am	noican Indian
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Is marked other then "natural", or Items 23a or 28e-f show other treumatic event, Ite Medical Exeminet must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces?  1 ⊠ Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 □ Yes 2፟፟ No	Specify:	to Rican, etc.)	Black, Wh	
2-0	72 ho	Completed	15. Decedent's Edu (Specify only highest grade	cation	16a. Deced	dent's Usual Occupa	ation	rkina	16b. Kind of Busines	s/Industry
21	within ene.	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	OO NOT use retired	i)	, , , , ,		
121	filed w Hygier thar th		12		Craf	tsman	10. Mathada Na	me (First, Middle, M	Self Emp	loyed
and	ould be fi Mental H arked ot atic ever	Be	17. Father's Name (First, Middle, Last)					,	waiden Surname)	
Maryland	2 should be filed within and Mental Hygiene. Is marked other then eumatic event, It o Me	ဥ	James Aloysius Stewart  19a. Informant's Name/Relationship (Ty	pe. Print)	19b. Mailir	no Address (Street a		elle Izett ural Route Number	City or Town, State,	Zin Code)
Ma	and 2 sealth an n 27 is		Jeanne Herbert / Siste	•				rge, Virgin		
re,	of Health item 27 I		20a. Method of Disposition	20b. F	_	sition (Name of natory or other place		-	20c. Location - City o	r Town, State
Ê			1 ☐ Burial 2 ☐ Cremation 3 ☐ R  1 ☐ Donation 5 ☐ Other (Specify)	ellioval irolli State		n Cremator	1		lexandria, V	/irginia
Baltimore,	permit. Page Department of Importent: If any injury on once.		21. Signature of Funeral Service Licens		22	. Name and Addres	s of Facility			8
8	88 = 8	-	Tyle	men_				neral Home, own, Maryla		
			23a. Part. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the deat ne cause on each line.	h. Do not ent	er the mode of dyin	g, such as cardia	c or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician		fmmediate Cause (Final disease or condition resulting in death)	Atheroscler	otic C	ardiovasc	ular Dis	sease		Offiser and Death
	/Medical Examiner		Testing in deality	Due to (or as a conseq	uence of):					
		ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq	uence of):					
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Indentity Cause (Disease or injury that initiated events							
o,	icate be executed physician and s the burial-transit	Exa	resulting in death) Last	Due to (or as a conseq	uence of):					
8760,	ate be nysici he bu	edicai		1						
9	e as t	Med	IF FEMALE:							
.О. Вох	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnance 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of degin Unknown	ideath 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
9	res that the digned by the be detached	/ Ph	Part II. Other significant conditions con	ntributing to death but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did tob	pacco use contribute	to the cause of death?
ds	luires r sign	d by						1 □ Ye	s 2 No 3 F	robably 4 Dunknown
Records,	w requir s been si should	Completed						24a. Was a	n 24b. Were a	autopsy findings available completion of cause of
Re	uicien: The lav certificate has rector, page 2	mo						autops perform	ned death?	
Vital		e e	25. Was case referred to medical			5	26. Place of Dea	ath (Check only on		yo his
<b>\</b>	S S TO	To B	examiner? 1 XYes 2 No	lospital: 1   Inpatient 2	ER/Outpatien	t 3 DOA Othe	er: 4 🗆 Nursing H	fome 5 ☐ Reside	nce 6 Other (Sp.	ecity) Zendine
n of			27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Worl	</td <td>28d. Describe ho</td> <td>w injury occurred</td> <td></td>	28d. Describe ho	w injury occurred	
Division	Attending r death. sctor: After oy the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be				Yes 2□No			
Ο̈́	or At after of Direct in by	rtifi	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str y)	eet, factory, office		City or Town	reet and Number or F n, State)	Rural Houte Number,
	pitel ours a nerel l	2	29a. Certifier 1 ☐ Certifying Phys	sician: To the best of my kno	wledge death	occurred at the time	ne date and place	and due to the ca	ause(s) and manner a	s stated
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edical		ner: On the basis of examina and manner stated.						
	To th To th comp	Me	29b. Signature and title of certifier	-		29c. License	e number	2:	9d. Date signed (Mor	nth, Day, Year)
•	CAD		MA	arty M		D1428	35		11-29	-04
	2		30. Name and address of person who co	impleted cause of death (fter	n 23a) (Type,					
	/		Dr. William D. Boyd,			Road, Leona	ardtown, Ma	aryland 206	50	
	Sta Regist	9 3	31. Date filed (Month, Day, Year) DEC 0 2	32. Registrar's Signa	iture A	And I				

Certificate of Death

		Director		135-44-1	228	1□M 2∰F	54	Yrs.	Months	Days	nours	Will.	8-9-	1950	N	ew Jers
		p ,		Usual Residence o	T		100 City	, Town or								10d. Inside
		death with the Maryland ms 23e or 28e-f show	_	10a. State	10b. County	3.6	1									1 ☐ Ye
		8e-1	Funeral Director	MD	L	Marys		Holly			_					
	7	or 2	Dire	10e. Street and Nu						Code				10g. C	itizen of What	•
	,	ath w	ral	20242 5	kyview D					0636						States
		r de	nue	11. Marital Status		Armed For		S. 13	. Was Dece If Yes, spe	dent of H cify Cuba	ispanic Or in, Mexicai	igin? (Spe n, Puerto I	cify Yes or N Rican, etc.)	0-	14. Race - Ar Black, Wi	nerican Indian, hite, etc.
9	036	2 should be filed within 72 hours after death with the Marylan and Memtal Hygiene. Is marked other than "naturel", or lieums 23e or 28e-1 show is marked other than "naturel", or lieums the rolling at reumetic event, it as Medical Exp., it at medical exp., it as the rolling at	by	1 Never Man	ried 2 Married X 4 Divorced	d 1 □Yes If Yes, Giv Year or Da	2 □ No e X ites:		1 🗆 Yes	2 <b>K</b> ] No	Specify:				Specify:	White
i	Baltimore, Maryland 21215-0036	in 72 ha n "natu vegicul	Completed	(Spe-		grade completed)	405.54)	16a. Dec (Giv life	edent's Usu re kind of wo DO NOT u	al Occup ork done d se retired	ation during mos 1)	t of workin	ng	16b. I	Kind of Busines	ss/Industry
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-	ğ	othe othe	Be C	17. Father's Name	(First, Middle, La	ist)					18. Moth	er's Name	(First, Middl	e, Maide	n Sumame)	
	<u> </u>	fenta fenta rked rked	To E	Harry	Charles	Spoerl						Jani	се К.	Bosi	eman	
	<u>۳</u>	shot nd N ma ume	_	19a. Informant's N				19b. Ma	iling Address	s (Street	and Numb				or Town, State	, Zip Code)
3	Š	5 <del>2</del> 2 <del>2</del> 5		Theodore	G. Sand	ers/Husba	and	2624	2 Skyv	/iew	Driv	e Hol	1vwood	1. M	D 20636	
	٠, ق	s 1 and 2 should if Health and Mer item 27 is marke other treumetic		20a. Method of Dis	position		20b. P		position (National				ate		ocation - City	
	ê.	m 0			☐ Cremation 3 5 ☐ Other (Spe	l □Removal from : ncifv)						12 <b>-</b> 4-	2004	G1o	ucester	City,
3		artme artme orter injur		21. Signature of		1	0.0				- 1				MD 2065	
- 1	ä	permit. Page Department of Importent: If eny injury or once.		1///	11.1.1	クフラア	While	4 18	rinsfi	ie1d	Fune	ral h	ome, I	.A.	22955	Hollywo
		- 1		23a. Part1. Enter shock, or hea	the disease, or cart failure. List or	omplications that control one cause on e	aused the death	. Do not e	nter the mod	de of dyin	ig, such as	cardiac o	r respiratory	arrest,		Approxima Interval B
		ากงร์เรเลก		Immediate Cause disease or conditi	(Final		ng Ca									2 mo
-		/Medical		resulting in death)	-	Due to (	or a a consequ	ence of):			11000					2 .70
김	1	Examiner			644	h										
SANDER			Je.	Sequentially list co if any, leading to it	mmediate	Due to (	or as a consequ	ence of):								
SA		uted d ansil	Examiner	Cause (Disease of that initiated event	S	c.										
¥ (	o,	exectan an an an rial-tr	Ex	resulting in death)	Last	Due to (	or as a consequ	ience of):								
ELEANOR	9/	certificate be executed ding physician and use as the burial-transit	cal			d										ļ
3 2	89	tifica ig ph as th	led													
i i	Box 68760,	eath certificate be executed attending physician and for use as the burial-transit	N/	IF FEMALE: 23b. Was deceder	nt pregnant	23c. If yes, out	come of pregna	ncy death 3	□Ectopic p	regnancy	,				23d. Date of c	
N (		0 0	by Physician/Medical	in the past 12 1 ☐ Yes 2 9 ☐ Unknowi	? months?		ant at time of de		Other (s)						Month	Day
اب	۵.	that the led by th detache	4	Part II. Other sign	ificant condition	s contributing to de	eath but not resu	ılting in the	underlying o	cause giv	en in Part		23e. Did	tobacco	use contribute	to the cause of
	ecords,	requires een sign hould be	d b										1)2	Yes 2	2 □ No 3 □	Probably 4
	Ö	w require been sig should b	pleted										24a. Wa	e an	24h Wore	autopsy finding
		as as	m d										aut	opsy formed?	prior t	o completion of
-	<u> </u>	i: The	Com										1 ☐ Yes	2 N	0 1 T	es 2 No
	<u> </u>	Physicien: The this certificate h ral director, page	Be	25. Was case refe examiner?		Hospital:				Oth	or		(Check only			
	ō	Phys this al dir	P		No	1 POL	npatient 2		_	UA	4 🔲 🛚 🔻	-	ne 5 Res		6 ☐Other (Sp	pecify)
	<u>_</u>	ing F	on:	27. Manner of Dea	5 Pending		of Injury th, Day Year)	28b. Time Injury	,	28c. Injur Wor	K?	1	tod. Describe	now inji	ury occurred	
	Sic	tend leath tor: / the f	cat	2 Accident	investiga 6 ☐ Could no	t ho			М		Yes 2	-	206	/C++-		December 1 Constant Alex
	Division of Vital R	I or Attend after death Director: / I in by the f	Certification:	4 Homicide	determin	289. Place	of Injury - At ho ng, etc. (Specify	me, tarm,	street, factor	y, office		1		own, Star		Rural Route Nu
1		urs a											- 1 1 - 1 11			
		To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funerel Director: After this certificate h completely filled in by the funeral director, page	Medical	29a. Certifier (Check only	2 Medical E	Physician: To the xaminer: On the ba	asis of examinal	wiedge, de tion and/or	ath occurred investigation	at the tir n, in my o	ne, date ar pinion, dea	nd place, a ath occurre	ind due to the	э cause(: э, date ar	s) and manner nd place, and d	as stated. ue to the cause
		To the I within 2 To the I complet	Med	one) 29b. Signature and	d title of certifier	and man	ner stated.		29	c. Licens	e number			29d D	ate signed (Mo	nth, Day, Year)
		No of Kit		230. Signature and		6-a6-4	MD		23		543	46			2/1/00	
	Ī										, T /	7				7
	per	_		30 Name and add	Iress of person w	ho completed caus	e of death (Item	23a) (Typ	e Print)							

2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Linda Eleanor Sanders NOVEMBER 29 9:23 p 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Hospital Saint Mary's Leonardtown 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 8-9-1950 9. Birthplace (State or Foreign Country) New Jersey 5. Social Security Number 6. Sex 10d. Inside City Limits 1 ☐ Yes 2 No . Citizen of What Country? United States 14. Race - American Indian, Black, White, etc. White Specify: b. Kind of Business/Industry Mail Order iden Sumame) seman City or Town, State, Zip Code) MD 20636 c. Location - City or Town, State oucester City, NJ MD 20650 . 22955 Hollywood Road Approximate Interval Between Onset and Death 2 months 23d. Date of delivery Month Day Year cco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No No ce 6 ☐Other (Specify) injury occurred et and Number or Rural Route Number, State) se(s) and manner as stated. e and place, and due to the cause(s)

CHANDRA SAJJA

31. Date filed (Month, Day, Year)

State Registrar DHMH 17 Rev 1/2001

**ORIGINAL** 

20636

PO BOX 640 HOLLYWOOD

32. Registrar's Signature

		•	For State Registrar	State of	Maryland		artment of rtificate of			F	Reg. No.	004	39295
	Physicia		Decedent's Name (First, Middle, Sadye STE	Last) INBERG					1	2. Date of Dea Month 2 (	o, 200	)4 Year	3. Time of Death 1:00 P M
	/Medio Examin		4a. Facility Name (If not institution,	give street and numb	per)		4b. City, Town,	or Location				ounty of Death	
			Independence Co				Hyatts		24 Hrs Ta	Date of Rist		ince Ge	
	Funeral Director		5. Social Security Number 6 57 9 - 42 - 8345	. Sex 7. 1 □ M 2 □ F	Age (In yrs. la. 97		Months Day		Min.	B. Date of Birt (Month, Day Aug • 3	190	7 Del	place (State or Foreign intry) Laware
			Usual Residence of Decedent  10a. State 10b. County		100 City	Town or Lo							10d. Inside City Limits
	Maryle f shov	ō		omeru			lver Spi	ino					1 ☐ Yes 2 ☑ No
	r 28e-	Irect	Maryland Montg  10e. Street and Number	Omery		01	10f. Zip Code				10g. Citize	n of What Cou	intry?
	23a o	ralD	8201 - 16th Stre					910				ed Stat	
036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylend Department of Health end Mental Hygiene. Importent: If Item 27 is marked other than "natural", or items 23e or 28e-f show any Injury or other treumatic event. The Medical Examinar must be notified at once.	by Funeral Directo	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Deced Armed Force 1 ☐ Yes 2 If Yes, Give Year or Date	es? ŒNo		Was Decedent of f Yes, specify Cu 1 ☐ Yes 2 2 N			ify Yes or No- ican, etc.)		Race - Amer Black, White pecify: wh	
Maryland 21215-0036	"natur	Completed	15. Decedent's (Specify only highest			(Give	dent's Usual Occ kind of work don DO NOT use reti	e during mos	st of working	9	16b. Kind	of Business/li	ndustry
121	within iene. then	dwo	Elementary/Secondary (0-12)	College (1-4	or 5+)		memaker	θα)			Own	n Home	
nd 2	al Hygi t other vent.	Be C	17. Father's Name (First, Middle, La							First, Middle,		ітате)	
yla	d Ment d Ment narked natic e	10	Jack Ber			10b Mailir	a Address (Stro			rchafte		oum State 7	in Codol
Mar	nd 2 sh alth end 27 Is n or treum		19a. Informant's Name/Relationship Samuel Steinberg			4106	ng Address (Stre Nichols	son St	reet,	Hyatt	svill	e, MD	20782
Baltimore,	Pages 1 and of Head of		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Spe		cer	metery, crer	sition (Name of matory or other p on Cemet		Da 11/23,			tion - City or T Lphi, N	
Balti	permit. Departn Importe any Inju		21. Signatur		_		orchinsi 54 Carro	-				n, DC	20012
			23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that call	ised the death.	Do not ent	er the mode of d	ying, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death
	Pnysician /Medical	8 1	Immediate Cause (Final disease or condition resulting in death)	-			ccident						Orisot and Dodg
	Examiner			0.000	ras a conseque								
	P =	ner	Sequentially list conditions, if any, leading to infimediate cause. Enter Underlying Cause (Disease or injury	b. Hyper	tension	ษกริย ปไ).							-
	end end il-trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c	r as a conseque	ence of):						-	
8760,	tate be executed obysicien end the burial-transit			d									
Box 6	death certific e ettending p d for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown		th 2 ☐ Fetal on that time of dea	death 3	Ectopic pregnar Other (specify)				230	d. Date of delive	very Day Year
rds, P.O	Se us	by	Part II. Other significant condition	s contributing to dea	th but not resul	lting in the u	nderlying cause	given in Part	l. 		obacco use 'es 2 🗆 I		the cause of death?
Vital Records,	The ete h page	Completed								24a. Was autop perfo 1 Yes		24b. Were aut prior to co death?	opsy findings available ompletion of cause of
Vita	Physicien: The this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			To	thor		(Check only o			
of		7: To	1 ☐ Yes 2X No 27. Manner of Death	28a. Date of	Injury 2	R/Outpatier 28b. Time o	IT 3 DOA	4 🗆 N		e 5∐Resid 3d. Describe h		ther (Speci eccurred	<sup>(y)</sup> Assisted Living
ion	Attending in death.	ation	1 Natural 5 ☐ Pending investiga	tion	Day Year)	Injury		Yes 2	]No				LIVING
Division	of or Atte efter de l'Directe d in by th	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	200. Place C	f Injury - At hor g, etc. <i>(Specify)</i>		reet, factory, offic	ө	28	3f. Location (5 City or Tow		lumber or Rui	al Route Number,
	To the Hospitel or Attending Phys within 24 hours efter death.  To the Funerel Director: After this completely filled in by the funeral di	edical C	29a. Certifier (Check only one)  Certifying  Certifying	Physician: To the bas and manne	is of examination	vledge, deat on and/or in	h occurred at the vestigation, in m	time, date ar opinion, dea	nd place, ar ath occurred	nd due to the	cause(s) ar date and pl	d manner as ace, and due	stated. to the cause(s)
)	To the within To the comp	Me	29b. Signature and title of certifier	ange	4	`		nse number b 4 (o	72		29d. Date s	eigned (Month)	Day, Year)
	-(		30. Name and address of person w Azhar Manipady		of death (Item 810 Cor	<sup>23a) (Type.</sup> nnect i	Print) Cut Ave	., Ken	singt	on, MD	208	95	
	Sta Registi		31. Date filed (Month, Day, Year)  NOV 2 4 2		gistrar's Signatu	# #	Sporks	/					

			1 - For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of H rtificate of			iene 9. N2 () () ()	39296
	Physici /Medic		1. Decedent's Name (First, Middle, Last) William C. Steng	er				2. Date of Deat Month November	Day Year	3. Time of Death 6:00 a.M
	Examin		4a. Facility Name (If not institution, give st 318 Thomas Avenu			Frederi			4c. County of Dea	
	Funeral Director		213-/6-1541	7. Age	67 Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	. (Month, Day,	9. Bir 26, 1937	rthplace (State or Foreign ountry)  Maryland
	aryland show	2	Usual Residence of Decedent	alr	10c. City, Town or Lo					10d. Inside City Limits 1 √2 Yes 2 □ No
	ith the M or 28a-1	Director	10e. Street and Number		rreder	10f. Zip Code		11	0g. Citizen of What Co	
36	within 72 hours after death with the Maryland ene. then "natural", or Items 23e or 28e-1 show ha Madical Exandinar relatible confilled at	by Funeral	318 Thomas Aven  11. Marital Status  1 ★Never Married 2 Married  3 ₩idowed 4 Divorced	2. Was Decedent E Armed Forces?  1  Yes 2 XN If Yes, Give Year or Dates:	lo I	21701 Was Decedent of F 1 Yes, specify Cub 1 ☐ Yes 2 🕱 No	Hispanic Origin? (	Specify Yes or No- orto Rican, etc.)	U.S.A.  14. Race - Ame Black, Whi	
Maryland 21215-0036	d within 72 hour jiene. r then "nature! the Medical Ex	Completed b	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of w	orking F	16b. Kind of Business Francis Sco Center	
and	d be filed ental Hyg ced othe c evant,	Be	17. Father's Name (First, Middle, Last) William Stenger					ome (First, Middle, A	Maiden Sumame)	
Baltimore, Maryl	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinating in the conditied at Once.	To	19a. Informant's Name/Relationship (Type Susan Holton - Dir 20a. Method of Disposition  1 Burial 2 Cremation 3 Rec., 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Ligense	ector Con Living	20b. Place of Dispo cemetery, cref Cedar Lav	620 Resessition (Name of natory or other plawn Memoria.	earch Dri	Date Cate Cate Cate Cate Cate Cate Cate C	City or Town, State, erick, Mary 20c. Location - City or agerstown, uneral Home	yland 21702 r Town, State Maryland
8760,	cate be executed /Medical Examiner and bhysician and street burial-transit transit cal Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Line funderlying Cause (Disease or injury that initiated events resulting in death) Last	Stroke Due to (or as a Chroni Due to (or as a Parkin	the death. Do not ent	er the mode of dyi	ng, such as cardi			Approximate Interval Between Onset and Death 1 day 4 yrs 3 yrs.	
P.O. Box 6	The law requires that the death certific the has been signed by the attending prage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of de Month	blivery Day Year
	w requires that been signed b should be deta	þ	Part II. Other significant conditions con  hypertension	tributing to death bu	ut not resulting in the u	nderlying cause gr	ven in Part I.	23e. Did tob	pacco use contribute to es 2 <b>⊠</b> No 3 □ P	to the cause of death?  Probably 4 Unknown
l Records,		Completed						24a. Was ar autops perform 1 ☐ Yes 2	y prior to ged? death?	utopsy findings available completion of cause of
Division of Vital	To the Hospital or Attanding Physician: Th within 24 hours after death. To the Funeral Diractor: After this certificate completely filled in by the funeral director, pag	To Be	25. Was case referred to medical examiner?  1  Yes	ospital: 1  Inpatie 28a. Date of Injur (Month, Day	ry 28b. Time o	f 28c. Inju	her: 4 🗆 Nursing		e) ince 6 Other (Spe w injury occurred	əcify)
Divisi	il or Attanding after death. I Diractor: After d in by the fune	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	ury - At home, farm, str c. (Specily)	reet, factory, office		28f. Location (St. City or Town	reet and Number or R n, State)	ural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dirt completely filled in h	edical C			of my knowledge, deat f examination and/or in ated.					
)	To the within To the comple	Me	29b. Signature and title of certifier		1.D	D4264	se number il Maryla		9d. Date signed (Mon. ovember 22	
	3		30. Name and address of person who con Stephen Lee M.D.	610 So	larex Cour		rick, Ma	ryland 2	21703	
	⊮ Sta Regist	ate rar	31. Date filed (Month, Day, Year) NOV 2 9		ar's Signature	B 1	par N. 1			

		•	1 - For State Registrar	State of Man			nt of Hea te of De				2004	39	297
and the same of	Physici /Medic		1. Decedent's Name (First, Middle, Las Matthew		Stepne	у			2. Date of Dea Month Novemb	Da			of Death
	Examir		4a. Fecility Name (If not institution, give Anne Arundel M		nter	4b. Cit	y, Town, or Loc Annar	ation of Death		A	nne Ar		L
1000	Funeral Director		5. Social Security Number 6. S 212-82-7732		n yrs. last birtho 39 Yr	Month		Under 24 Hrs. ours Min.	8. Date of Birth Month, Day July 3	h V. Year)	965 9. Bir	hplace (Stat untry) lary1a	e o <i>r Foreign</i> and
	show	or	Usuel Residence of Decedent  10a. State 10b. County  Maryland Anne A		Oc. City, Town o		River			-,-,-			City Limits
	with the N a or 28a-	Direct	10e. Street and Number 5167 Sudley R				Zip Code	78		10g. Cil	tizen of What Co	untry?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show appring yor other traumatic event, the Medical Examiner must be neithed at ance.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Morried	12. Was Decedent Eve Armed Forces? 1  ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates:	or in U.S.		cedent of Hispar pecify Cuban, M		pecify Yes or No- pecify Yes or No- pecify Yes or No-		14. Race - Ame Black, White SpecifyB 1 a	e, etc.	,
Maryland 21215-0036	d within 72 hou piene. r than "natura the Medicel E	Completed by	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or 5+)	((	Give kind of the DO NOT	sual Occupation work done during use retired)	ng most of wor	king		ind of Business. ce Coπ		
land ;	uld be filed Aental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last) Samuel		Ford			Mother's Nam Franci	ne (First, Middle, e	_	pney		
	ind 2 should lath and Men 127 is marke		19a. Informant's Name/Relationship ( Francie Stepne						ral Route Numbe est Riv				
Baltimore,	Pages 1 and the properties of		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specification)	Removal from State	Ernest	ineJo	nother place) nes Ce	em.11/	Date 24/04	Che	-	e Bcl	
Balti	permit. Page Department Important: If any injury or once.		21. Signature of Funeral Service Licer	Sevel		22. Name 1451 Princ	and Address of Dares e Fred	Facility Se Beach derick	well F Rd. MD 2	une 067	ral Ho 8	me	
100	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	e death. Do no	k enter the m	ode of dying, su ly Fai	uch as cardiac	or respiratory ar	rest,		Approxin Interval E Onset an	Between nd Death
3760,	te be executed ysician and the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c	onsequance of								% %
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death	3 □Ectopic 5 □ Other					23d. Date of de Month	ivery Day	Year
	w requires that s been signed b should be deta	ρ	Part II. Other significant conditions of PNEMWOW	-	not resulting in t	he underlying	g cause given in	Part I.	23e. Did to		use contribute to	the cause of the c	
Vital Records,		Completed							24a. Was autop perior 1  Yes		death?	completion o	gs available cause of
	Physician: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1 Yes 2 M No	Hospital: 1 Inpatient	2 ER/Outp	atient 3	Othor		th <i>(Check only o</i> ome 5 - Resid		6 □Other (Spe	city)	
ion of	Jing After fune		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	2 🗆 No	28d. Describe h	now inju	ry occurred						
Division	tal or Attencts after death	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e. Place of Injury building, etc. (	· At home, farn 'Specify)	n, street, fact	ory, office		28f. Location (S City or Tox		nd Number or R. e)	ural Route N	u <i>mber</i> ,
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in b	ledical		nysician: To the best of r miner: On the basis of ex and manner state	camination and/								e(s)
)	To the within To the comp	Ž	29b. Signature and title ercertifier	Bech, MD		2	D 46	mber 052		29d. Da	ite signed (Mont		)
	2		30. Name and address of person who	completed cause of dear	th (Item 23a) (T Wedica	ype, Print)	way (	annap	olis, M	D	Canal	217,200	
	St. Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	6.P. o.							

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 00 0 39298 For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Yee **Physician** 14:25 Evelyn Hilda Shaw 04 25 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CUMBERLAND ALLEGANY SHCRED HEART HOSPITAL If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Date of Birth (Month, Day, Year, 22-Jun-1927 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🔀 F Pennsylvania 77 215-36-8740 Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County 28a-f show traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Maryland Allegany Cumberland Directo 10e. Street and Number 11817 Bayberry Ave. 10g. Citizen of What Country? 10f. Zip Code filed within 72 hours after death with 0 21502-U.S.A. Itama 23a Be Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 KNo If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕱 No Baltimore, Maryland 21215-0036 ō Specify: Specify White 3 Widowed 4 □ Divorced "natural". 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Reaistered nurse state university 3 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental Hisant: If itam 27 is marked other Ellen Witt William Opel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 309 Harmony Way 19a. Informant's Name/Relationship (Type, Print) daughter Berkley Springs West Virginia 25411-Janet Michael 20b. Place of Disposition (Name of cometery, crematory or other place)
Sunset Memorial Park 20c. Location - City or Town, State 20a Method of Disposition Department of H Important: If its any injury or of once. **≸**Burial 2 ☐ Cremation 3 ☐ Removal from State 30-Nov-2004 Cumberland Maryland • 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Liga 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 ne 2 23a. Paof. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Multiple Prosician nouth disease or condition resulting in death) /Medical Due to (or as a consumence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-tran ding physician and resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day ŏ 4☐Pregnant at time of death 5 Other (specify) P.O. | the 9 Unknown à 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ -aulus 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes Hospital or Attanding Physician: director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manger of Death After 1 WNatural 5 Pending 1 🗌 Yes 2 🗌 No hours after death. investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide filled in within 24 hours a To the Funaral C 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier w 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) New George, Creek S. W. Frostlein, Mary and 2103. LURNINA CHANG MO ひと F 10701 31. Date filed (Month, Day, NOV 2 9 32. Registrar's Signature State 2004 Registrar

			For State Registrar		State of M	aryland / De <sub>l</sub>	oartmen e <i>rtificat</i>					giene Reg. No.	004	392	299
			1. Decedent's Name	(First, Middle, Las	t)						2. Date of De Month	ath Day	Year	3. Time	of Death
	Physicia /Medic		Robert	Ρ.		Steward					NOVEMBI		2004	15:	40 M
	Examin		4a. Facility Name (If r	not institution, give	street and number)				Location of			4c. Co	ounty of Dea	th	
			MEMORIAL			e (In yrs. last birthda			RLANI If Under		8 Date of Bir	th	ALLEG	ANY thplace (State	o or Foreign
	Funeral Director		5. Social Security Nui 216-30-16	- 11	M 2 F	Yrs. Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Jul 9, 1	y Year) 1933	3. G	MD	e or roleigh
	ס		Usual Residence of D	Decedent										T	
	anylan show	Ļ	10a. State	10b. County	\ /	10c. City, Town or	Location  berlan	d							City Limits es 2 ☐ No
	he Ma 88-1	ecto		Allegan	У	Cuit	10f. Zip					10a Citizo	n of What Co		
	a or 3	Ö	10e. Street and Numl		venue Apt	503	101. 212		1502	•		1	USA	builty:	
	72 hours after death with the Maryland neturel; or Items 23a or 28e-f ehow Jisal Exar it wit must be netified at	Funeral Director	11. Marital Status	Herville A	12. Was Decedent		3. Was Dece				ecify Yes or No Rican, etc.)	. , ,	Race - Ame	erican Indian,	
9	after or Ite	교	1 Never Marrie	d X Married	Armed Forces? 1 ☐ Yes 2 ☐ IXYes, Give	No	If Yes, spe-		n, Mexicar Specify:	1, Риепо	Hican, etc.)		Black, Whit	te, etc.	
5-0036	urel',	d by	3 ☐Widowed 4		Year or Dates:	Korea							wn		
15-(	"nett	Completed	(Specif	15. Decedent's Ed y o <i>nly high</i> est gra	ucation de <i>completed)</i>	16a. De	edent's Usua ve kind of wo . DO NOT u	al Occupa ork done d se retired	ation fu <i>ring m</i> os 1	t of work	ing	16b. Kind	of Business	/Industry	
2121	filed within Hygiene. Ither then "	шо	Elementary/Second	dary (0-12)	College (1-4or	5+)	r/oper					Bob's	Uphol	sterv	
d 2	e filed Hyg other	Be C	17. Father's Name (F	irst, Middle, Last)		<u> </u>			18. Mothe	ər's Namı	e (First, Middle				
/lar	2 should be filed within and Mental Hygiene. Is marked other then aumatic event, the Ms	ToE	George	Steward							DuVall S				
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "neturel; or items 23a or 28e-f show appring yor other traumatic event, the Medical Examination at most be rediffed at once.	. 1	19a. Informant's Nar		<sub>урө, Print)</sub> wife		iling Address ) Somr	1			al Route Numb	er, City or T perland		Zip Code) D 215	<b>02</b>
	1 and Health em 27		Shirley St		WIIC	20b. Place of Dis	position (Nai	me of	Ţ		Date			Town, State	02
nor	Pages nent of int: If its	1	1 🔀 Burial 2 🗆		Removal from State	Rocky Gar	rematory or o			v	12/2/2004	4	stone		MD
Baltimore,	permit. Pag Department Importent: I eny injury c		21. Signature of Fun			ritotity our	22. Name ar	nd Addres	s of Facili	tv		1 11110	Storic		VID
B	permit. Departr Importe eny inji		Yalav	ms 7	And	u					me, PA ∷Cumber	land M	ID 2150	12	
			23a. Part1 Enter the	e disease, or comp	plications that cause one cause on each I	d the death. Do not one.	enter the mod	de of dying	g, such as	cardiac	or respiratory a	rrest,	10-2-100	Interval 8	Between
	Physician		Immediate Cause (F disease or condition resulting in death)	inal	. Acute	2 Myoca	rdia	LI	こった	arc	tion			Onset an	
8760,	/Medical Examiner  bhysician and sthe burial-transit	ical Examiner	Sequentially list con- if any, leading to imr- cause. Enter Underl Cause (Disease or in that initiated events resulting in death) La	lying njury	b. Coron Due to (or as	a consequence of):	tery	Di	sea	se				5 year	ers
P.O. Box 68	The law requires that the death certificate has been signed by the attending plate as should be detached for use as I	Completed by Physiclan/Medical	IF FEMALE: 23b. Was decedent in the past 12 n 1  Yes 2 9	nonths?	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death	3 □Ectopic p 5 □ Other (sp					230	d. Date of de Month	livery Day	Year
	s that med b	y Pi	Part II, Other signific	2.0				_			23e. Did t	tobacco use	contribute to	o the cause o	of death?
rds	w require been sig should b	edt	Chronic R	•	•		neruk	nepi	nriti	5	1 🗆	Yes 2 M&I	No 3∏P	robably 4	Unknown
Division of Vital Records,		Complet	Cardion	nyepat	hy, Di	abetes					24a. Was auto perfo 1 \( \text{Yes} \)	an psy prmed? 2 No	24b. Were a prior to death?	utopsy finding completion of s 2 No	gs available if cause of
/ita	Physicien: this certific ral director,	Be	25. Was case referre	T.	Hospital:			Othe	300		h (Check only				
of	Physic this cral dir	P.	1 ☐ Yes 2 ⚠ N 27. Magner of eath	No	1 ☐ Inpati		_	JA	4 14	ursing Ho	me 5 Resi			ecity)	
O	ng fter ine	tion	1 Natural 2 Accident	5 Pending investigation	(Month, Da	y Ye <i>ar)</i> Injur	м	28c. Injury Work 1 🔲 `	<br Yes 2 □	No		. ,.,			
Divisi	al or Attending after death. I Director: After d in by the fune	ertification;	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of In	jury - At home, farm, tc. (Specify)	street, factor	y, office			28f. Location ( City or To		Number or R	ural Route N	umber,
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C				of my knowledge, de of examination and/o tated.						date and pl	ace, and du	e to the caus	
	To the within To the Comp	M	29b. Signature and t	61 /1 //	M		29	c. License						th, Day, Year	
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	1		DR. N. R 31. Date filed (Month	ANJITHAN		FOWN RD.,	CUMBER	RLAND	), MD		21502	-			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** 2004 Jacob /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** HICOME REGIONAL SALISBUK PENINSULA MEDICAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8-/3-/9. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1**™**M 2□ F 216-34-0085 Hours 66 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examinar must be notified at Accomac 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23336 8186 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ₽ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 Yes 2 No Baltimore, Maryland 21215-0036 ō Specify: Specify: White Completed by 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ent; If item 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Shipping Shipping 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surmame) Be Jacob Till Barbara 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Va 8186 Sea Spray Chincoteague 23336 wife Patricia Till 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date permit. Pages Department of Importent: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chincoteague 111-23-04 Island Crematorium 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 5049 Chicken City Rd Fox . Holston Funeral Home Chincoleague Va. 23336 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit or Attending Physicien: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as the t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? been signed þ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 1 Yes 2 🗆 No 2 4NO Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARCOIL

State

Registrar

M.O.

NOV 2 3 2004

31. Date filed (Month, Day, Year)

100 32. Registrar's Signature

Amend Item 8 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Tensure All Copies Are I State of Maryland / Department of Health and Mental Hygiene, Hegistrar WCHDSH 12/6/04 per FH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** November Dorothy Louise Turner 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington County Hagerstown Washington County Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) 29,9. Birthplace (State or Foreign 6. Sex **Funeral** 1 ☐ M 2 🗓 F Yrs. 76 219-20-2720 Director <del>39</del> 1928 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show ir than "natural", or items 23a or 28a-f show 1 ☐ Yes X☐ No Directo Maryland Washington
10e. Street and Number Maugansville 10f. Zip Code 10g. Citizen of What Country? death with 21767 U.S.A. 13905 Completed by Funeral Weaver Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X ☐ No Specify: Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Garment Mfg. Seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ould be Mental is markad c permit. Pages 1 and 2 should be Department of Health and Menta Important: If Itam 27 is markad any injury or other traumatic events. <del>Lena Gam Wilson</del> Lena Kregelo Albert Mongan ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13905 Weaver Ave. Maugansville, Maryland 21767 Kathy R. Kline (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 12/4/04 Hagerstown Maryland Cedar Lawn Mem Park <sup>1</sup> 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Slvd. N. Hagerstown Maryland 21742 auna Luy 23a. Part1. Enter the discrete, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail if e. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Kest tu lune **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Year in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the detached 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☐ No Nupatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this filled in by the funeral 28a. Dan of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Attanding 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Diractor: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō Hospital 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical To the within 2 and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 60228 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1) A A h m x d 12821 CLK Hill HUE 2821 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 03 Registrar

State of Maryland / Department of Health and Mental Hygien $oldsymbol{2}$   $oldsymbol{1}$   $oldsymbol{1}$ For State Registrar 39302 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DECEMBER 1, 2004 **Physician** 1835 RUTH GRADY TATUM FITCH /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 7624 MOUNTAIN LAUREL ROAD **BOONSBORO** WASHINGTON | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Min. | DEC . 13, 1 9. Birthplace (State or Foreign Country)
VIRGINIA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□ M 2 KF Yrs. 227-40-9004 69 Director Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "neturel", or Items 23s or 28e-f show other treumetic event, the Medical Evaminer must be nigited at 1 ☐ Yes 2 No Director MARYLAND WASHINGTON BOONSBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7624 MOUNTAIN LAUREL ROAD 21713 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 0 1 ☐ Yes 2 🖾 No Specify. ል 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY/ADMIN. BUSINESS OFFICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental H lent: If item 27 is marked ott Be DAVID TATUM HATTIE MAE SHEFFIELD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LAWRENCE A. FITCH, HUSBAND 7624 MOUNTAIN LAUREL ROAD, BOONSBORO, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State ò permit. Page Department o Importent: If SMITHSBURG CREMATORY 12/02/2004 SMITHSBURG, MARYLAND \*4 □Donation 5 □ Qther (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 7606 OLD NATIONAL PIKE any. BAST FUNERAL HOME telly A. Limmerman BOONSBORO, MARYLAND 23a. Part Eth the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician asmi month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (See Section 1997) that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) the the 9□ Unknown 9 ☐ Unknown ģ signed of 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ፩ 1 Yes 2 No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed? certificate 1 ☐ Yes 2 ⊡ No : After this certification and funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident To the Funeral Director: completely filled in by the 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 0 nours after Hospitel within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 12.2.04 notion 04166 MA nuhael 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Nediza meele 11110 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760,

Replacement

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Mary	•	artment of H			ene 1. No. 2004	39303
			1. Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
и	Physici		Abelardo	Gilberto	Temoche	Benites		Month November	23, 2004	9:45 A. M
	/Medio Examin		4a. Fecility Name (If not institution, give s		1011100110		Location of Death		4c. County of Dea	
	_xumm		Shady Grove Adven	tist Hospit	:a1	Rockvi	111e	:	Montgo	nerv
	Funeral		5. Social Security Number 6. Sex		yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Bir	thplace (State or Foreign
ш	Director		214-60-4378	M 2□F	81 Yrs.	Months Days	Hours Min.	July 13,	4000 -	eru
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	e Ma	cto	Maryland Montgome	ry	Montgom	ery Villa	ge			1 Tyes 2X No
	th th or 28	)ire	10e. Street and Number			10f. Zip Code		100	j. Citizen of What C	ountry?
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	within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28e-f show w Medical Exertine from the codified at	by Funeral Director	11. Marital Status	<ol><li>Was Decedent Ever Armed Forces?</li></ol>		Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	
98	or It	y F.	1 ☐ Never Married 2X Married	1 ☐ Yes 21X No If Yes, Give		1⊠Yes 2□ No	Specify:		Specify:	
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Maryland 21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Marylar at G Health and Mental Hygiene. If Item 27 Is marked other than "natural", or Itams 23s or 28s-f show or other traumatic event, the Wedical Erapin errors the rotified at									
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Baltimore,	permit. Pages 1 and Department of Heall Important: If Item 2 any injury or othar onea.		21. Signature of Funeral Service Licentie	bu		2. Name and Addres				
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	/Medical Examiner		resulting in death)	Due to (or as a con	nsequence of):					
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8760,	icate be executed physician and s the burial-transit	dical								
9		Me	IF FEMALE:							
Box	eath certif attending for use a	an/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pr 1 ☐ Live birth 2 ☐	Fetal death 3[	Ectopic pregnancy			23d. Date of de Month	livery Day Year
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ŝ	Se Che	by	Part II. Other significant conditions con	thouting to death but no	n resulting in the t	indenying cause givi	en arti.			robably 4 MUnknown
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ec	as to see	ompleted						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
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of Vital Record	sician: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?				26. Place of Death	(Check only one)		
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			27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of Injury (Month, Day Yea	ar) 28b. Time o	f 28c. Injun Worl	y at k?	28d. Describe how	injury occurred	
ioi	Attending r death. actor: After by the fune	atle	2 Accident investigation			M 1 🗆	Yes 2 □ No			
Division	l or Attend after death Diractor: /	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, st pecily)	reet, factory, office		<ol> <li>Location (Stre City or Town,</li> </ol>	et and Number or R State)	ural Route Number,
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}			Joseph M.	Tappeny	7 - 20	D 3	2407	N	ovember 2	3, 2004
			30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type,	Print)				
_			Joseph M. Haggerty	M.D., 970	7 Medica	1 Center	Dr., #300	), Rockvi	lle, Mary	land 20850
	Sta		31. Date filed (Month, Day, Year)	3 Registrar's	Signature	act o				
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	/Medic Examin		Elaine Johnson Tw 4a. Facility Name (If not institution, give s 3005 S. Leisure Wo	treet and number)	7	4b. City, Town, or Silver	Sprin	Death 2	ovembe		2004 inty of Deat gomer	h	
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	Maryland a-f show	tor	10a. State 10b. County  Maryland Montgome		y, Town or Lo							10d. Inside	City Limits
	with the a or 28s	Director	10e. Street and Number	-1.1 D1 4 #E	17	10f. Zip Code			1	l 0g. Citizen		untry?	
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Maryland 21215-0036	within 72 hou ene. than "natural in Wedical E	Completed I	15. Decedent's Edu (Specify only highest grade	cation	(Give	dent's Usual Occupi kind of work done o DO NOT use retired ement Ana	during most o	of working				Industry nstitu	tes
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	alth and 2 should be shoul		19a. Informant's Name/Relationship (Tyr. Donald J. Twillma			ng Address <i>(Street a</i> S. Leisur							20906 , MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event. The Wedical Exact is constituted at once.		20a. Method of Disposition  1 Burial 2 Cremation 3 R  4 Donation 5 Other (Specify)  21. Signature of Funeral Service License	emoval from State Ft	• Linc	sition (Name of natory or other place oln Crema 2. Name and Addres 800 New H	atory ss of Facility	Hines-	'2004 -Rinal	Brent di Fu	wood, neral	Home	20904
	Priysician /Medical		23a. Part1. Enter the disease, or complishock, or hearf failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the deather cause on each line.  Myocard  Due to (or as a consequence)	h. Do not ent ial In	er the mode of dyin					БРГІП	Approxima Interval Be Onset and	ate etween
8760,	Examiner	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying tust process of the cause through that initiated events resulting in death) Last	Due to (or as a conseq  Due to (or as a conseq  Due to (or as a conseq	uence of):								
.O. Box 687	The law requires that the death certificale be executed atte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 M No 9 □ Unknown	3c. If yes, outcome of pregns 1 Live birth 2 Feta 4 Pregnant at time of d	death 3	Ectopic pregnancy Other (specify)	,	-		23d.	Date of deli Month	ivery Day	Year
<u>a</u>	quires that n signed b	by	Part II. Other significant conditions cor	ntributing to death but not res	ulting in the u	nderlying cause give	en in Part I.		23e. Did to			the cause of obably 4	
l Records,		Completed							24a. Was a autops perfor	sy	prior to death?	itopsy finding completion of	s available cause of
Vital	Physician: Th r this certificate ral director, pag	o Be (	25. Was case referred to medical examiner?  1 \( \text{Yes} \) 2 \( \text{X} \) No	fospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	at 3□ DOA Oth		of Death (Ch	**	ence 6 🗆	Other /See	nife)	
Division of	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Diractor: After this certific completely filled in by the funeral director.	<b> </b>	27. Magner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	28c. Injun	y at	28d.		ow injury oc		эну)	
Divis	To the Hospital or Attending within 24 hours after death. To the Funeral Diractor: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, sti ý)	eet, factory, office		28f.	ocation (S City or Tow	treet and Nu n, State)	umber or Ru	ıral Route Nu	mber,
	ne Hospita 124 hours 18 Funeral bletely filled	edical		sician: To the best of my kno ner: On the basis of examina and manner stated.									(s)
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			30. Name and address of person who con Richard P. Delaney		Ferrar	Print) a Drive,	Wheato	on, MD	209	06			
	Sta Registi		31. Date filed (Month, Day, Year) NOV 2 4 20		G	Spark							

Please Type or Print in Black Indelible Ink	Ensure All Copies Are Legible.
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			For 1 = State	State of Ma	ryland / l	•	nent of H		nd Mental I	Hygiene Reg. Nd	2001	30305
			Registrar  1. Decedent's Name (First, Middle, Las	t)		00/11/1/	0010 01 2		2. Date of	Death		3. Time of Death
	Physici		ALGERNON TILLER						NOV.	21.20	y Year 104	12:15P M
	/Medic Examin		4a. Fecility Name (If not institution, give	street and number)		4b.	City, Town, or	Location of D			County of Dea	
			CIVISTA MEDIC.				LAPLA			С	HARLES	
П	Funeral		5. Social Security Number 6. Se	744 00 5 1	(In yrs. last bii		nths Days	If Under 24 Hours	Min. 8. Date of (Month	Birth Day, Year) 26 19:	9. Bin	thplace (State or Foreign ountry)
	Director		159–26–7907 Usual Residence of Decedent	X /	74	113.			Sept	26 19.	30 Ma	ryland
	yland now		10a. State 10b. County		10c. City, Tow		n					10d. Inside City Limits
	a-fel	ctor	Maryland Charles		New	burgh						1 □Yes 2X No
	or 28	Dire	10e. Street and Number			10	Of. Zip Code			10g. Cit	izen of What C	•
	s 23a	Funeral Director	9700 Orlend Park		S-2-1-11-0	10.34		664	0.70		US 14. Race - Am	
_	item item	-une	11. Marital Status 1 □ Never Married 2 Married	12. Was Decedent E Armed Forces? 1 MYes 2 □ N				n, Mexican, P	n? (Specify Yes or Puerto Rican, etc.	No-	Black, Whi	te, etc.
2	urs af	þ	3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ N If Yes, Give Year or Dates:		101	∕es 21X No	Specify:			Specify: B1	ack
ה ה	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23a or 28a-f ehow ent, I're Medical Examiner man be notified at	Completed	15. Decedent's Ed (Specify only highest grad		16a	. Decedent's	S Usual Occupa	ation	f working	16b. K	ind of Business	/Industry
7	athin 19.	mpie	Elementary/Secondary (0-12)	College (1-4or 5-	+)	iife. DO N Millwr	of work done of	)	, monning	Dri	ug Manu	facturing
7	iled w Hygier ther th		12 17. Father's Name (First, Middle, Last)		1	TITIME	igne	18 Mother's	Name (First, Mic	Idle Maiden	Sumamal	
2	ntal h	) Be	Richard Tiller						ace Till		Samane)	
5	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Important: if item 27 is marked other than "naturat, or items 23a or 28a-f show any injury or other traumatic event, Iria Maclical Examination in all be notified at ance.	ဥ	19a. Informant's Name/Relationship (7	ype, Print)	198	b. Mailing Ad	Idress (Street a		or Rural Route Nu		r Town, State,	Zip Code)
2	nd 2: alth ai 27 is r trau		Minniua L. Tiller	(wife)	97	700 Or	lend Pa	ark Rd	. Newbur	gh, Ma	aryland	20664
ກັ	es 1 a of Hec item		20a. Method of Disposition	D	20b. Place o	of Disposition	n (Name of ry or other place	θ)	Date	20c. Lo	cation - City or	Town, State
altillor	Page ment a		1	)		olitan	Crema	tory 1	1-22-04		xandria	
	Departi Departi Importi any inj once.		21. Signature of Fineral Pervice Licen	MO017	13	22. Na	me and Addres	s of Facility	Eberwein	Fune	ral Ser	vices
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			23a Part1. Enter the disease, or comp shock, or heart failure. List only of minediate Cause (Final	one cause on each lin	e.					ry arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Card	liac	0	cripth	mid	L			
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2	Atter r dea ector by the	ertification;	3 Suicide 6 Could not be determined	28e. Place of Inju		arm, street, f	actory, office			n (Street an Town, State		ural Route Number,
5	s after or s after or	Cert	4   Homicide	building, etc	. (Зреспу)				City di	TOWN, State	/	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica	edical		ysician: To the best o								
	the hin 24 the F	Medi	one)	and manner sta	ted.		29c. License					
	Wit To Cor		29b. Signature and title of certifier.	(K.)				05694	0	1 1	a signed (Moni	
1			30. Name and address of person who o		ath (Itom 33a)	(Type Drine	1	03094	7	1 1	7.10	
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	Registr	0.0	WINDN W. H.	004	· M		10					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1 2004 **Physician** Month. 11 12:40AM Peggy Ruth Taylor /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Georges 1427 Southern Ave#202 <u>Oxon Hill</u> 8. Date of Birth (Month, Day, Year) 9/3/1946 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F N.C. Director 218-33-6593 58 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturst", or items 23a or 28a-f show other treumatic event, the Madical Examinar must be notified at Director 1 XYes 2 No Oxon Hill P.G. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20745 1427 Southern Ave#202 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□ Yes 2□ No Specify: Specify: Black þ 3√2 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Counselor Private 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be should be Hazel Harris John H. Reid 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 4347 4th St.S.E.#12Wash. D.C. 20032 Elease Taylor/daughter 20b. Place of Disposition (Name of cemetery, crematory or other pla 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. Resurrection Cem. 11/18/04 Clinton, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hodges and Edwards 3910 Silver Hill RD.Suitland, MD.20746 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 170 Carda 10kno /Medical Due to (dras a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): death certificate be executed and Due to (or as a consequence of): the attending physicien a ned for use as the burial-Box 68760, Physician/Medicai use as IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed this certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No After this certification, funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2€ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification 5 Pending 1 X Natural To the recent within 24 hours after death.

To the Funerel Director: Aft 1 ☐ Yes 2 ☐ No М investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ö 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) The I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 11.16.04 D43446 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9801 Georgia scinta Factoritar MO Are suit 3-41 silverspring MD 20902 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 1 0 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Movember 20,2004 **Physician** Curtis 3:30 am William Vickers /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Coastal Hospice at the Lake Salisbury Wicomico If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 12/29/1925 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 X M 2 □ F Maryland 78 215-20-2032 Director Usual Residence of Decedent the Maryland 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits s 23a or 28a-f show ust be notified at Maryland Wicomico Salisbury Director 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 351 Deers Head Hospital Road 21801 USA Funerai or Items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status r than "neturel", or Items It is Medical Exertiner filed within 72 hours after 1 X Yes 2 □ No If Yes, Give Year or Dates: Na.Vy 1 ☐ Never Married 2X Married 21215-0036 1 ☐ Yes 2 No Specify: white Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) nd Mental Hygiene. marked other than Manager Storer Communications 12 Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be f nent of Health and Mental I ent: If item 27 is marked o Troy T. Vickers Bernice Heath 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) : If item 27 or other t Lois A. Vickers/wife 6409 Willing Dr., Salisbury, MD 21801 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Springhill Memory
Gardens 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Department of Importent: If eny injury or once. 11/23/2004 Hebron, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lidensee 22. Name and Address of Facility Holloway Funeral Home Professional Association (F)P 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Dea Immediate Cause (Final disease or condition resulting in death) Physician ue to (or as voinsequence of): 6 MON /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). or Attending Physicien: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medicai the IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐ Pregnant at time of death 5 Other (specify) of Vital Records, P.O. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ed bluods 2XNO 3 Probably 4 Unknown 1 Tyes Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? page 2 1 Yes 1 TYes director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 🗌 Yes 1 Impatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Teath Certification; 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? Division Natural 5 Pending investigation Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide Hospital 24 hours a Medicai 29a. Certifier Prifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b Signature and completed cause of death (Item 23a) (Type, Print) 00 2 3 2004 State Registrar

			For State Registrer	State o	f Marylan		artmeni rtificate				ental Hy	giene		39308
ı	Physici		Decedent's Name (First, Mic Gloria Anne Whi								2. Date of De Month December	Day		3. Time of Death  10:45 A. M
	/Medio		4a. Facility Name (If not institu		nber)		4b. City,	Town, or	Location of		occumber.		County of Dea	
	٥		St. Mary's Nurs	ing Center				nardt					t. Mary'	S
н	Funeral		5. Social Security Number	6. Sex 1 □ M 2 √2 F	7. Age (In yrs. 64	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bit (Month, Da		_ C	rthplace (State or Foreign ountry)
Η,	Director		215-38-3946 Usual Residence of Decedent	21			l				January	2,1940	0 Mar	yland
	nyland ihow		10a. State 10b. Cour	nty	10c. City	y, Town or Lo	cation							10d. Inside City Limits
	se Ma	Director		lary's	Leor	nardtown			_					1√ Yes 2 □ No
	with the or 2	Dire	10e. Street and Number	a Carret			10f. Zip						zen of What C	ountry?
	leath ns 23	Funeral	22680 Cedar Lar		dent Ever in U.	.S. 13.	206.		spanic Ori	ain? (Spe	cify Yes or No		SA 14. Race - Ami	erican Indian
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23e or 28e-f ahow any injury or other traumatic avant, if a Mydical Exertified at Once.	þ	1 ☐ Never Married 2 ☐ M	Armed Fo 1 ☐ Yes If Yes Giv	rces? 2 TNo e		fYes, spec 1 ☐ Yes 2		Specify:	i, Puèrto F	cify Yes or No Rican, etc.)		Black, Whi	te, etc.
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Maryland	12 should be filed within "h and Mental Hygiene." Fie marked other than "reumatic avant, It e Men	-	19a. Informant's Name/Relation	onship (Type, Print)		19b. Mailir	ng Address	(Street a					r Town, State,	Zip Code)
Σ,	and 2 ealth n 27 i		Roger Anthony W	hite/Son					oad, A	-	Mary1an	d 2060	06	
Baltimore,	Pages 1 nent of H int: If itar	-	20a. Method of Disposition 1 □XBurial 2 □ Crematic	n 3 Removal from	20b. P Char	lace of Dispo emetery, cren les Mem	sition (Nam natory or ot orial	e of her place	)	2004	ate	20c. Lo	cation - City or	Town, State
iii E	it. Pa rtmen rtant: njury		' 4 ☐ Donation 5 ☐ Other  21. Signature of Funeral Servi			Garden	S		\D	ecembe		eonar	rdtown,Ma	aryland
Ba	permit. Departr Imports any inj		Michaely	win Hor	l_)	-	Leonard	gley-(	Gardin Mary	er Fur 1and	20650		.A., P. c	D. Box 270
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687	fficate g phys	edlcal		d										
Вох	eath certific attending p for use as	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregna		Ectopic pre	anancy				2	3d. Date of de	•
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	res that the de igned by the be detached	y Ph	Part II. Other significant cond	itions contributing to de	ath but not resu	ulting in the ur	nderlying ca	use give	n in Part I.		23e. Did to	obacco us	se contribute to	the cause of death?
Records,	w requires been sign should be	q pa									10	Yes 2	No 3□Pr	robabiy 4 Unknown
9 6 6	e taw re has bee	Completed									24a. Was		24b. Were au	utopsy findings available completion of cause of
_		Com									perfo	rmed? 2 No	death?	
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medi examiner?	Hospital			-		137.04		Check on o			
ot	Phys r this ral dir	. To	1 ☐ Yes 2 No 27. Manner of reath	28a. Date o		ER/Outpatien 28b. Time of			4 A Nul		e 5 🗌 Resid		Other (Spe	cify)
on	nding th: :: Afte e fune	atlon	1 X Natural 5 ☐ Pen		h, Day Year)	Injury	М	Bc. Injury Work 1   Y	? es 2 □ h		, Describe ,	TOTT III JULY	Cocarred	
Division of	I or Attending Phy after death. Director: After this I in by the funeral d	Certification:	3 ☐ Suicide 6 ☐ Cou	ld not be	of Injury - At ho	me, farm, str	eet, factory,	office		28	3f. Location (S City or Tox		d Number or Ru	ural Route Number,
	ital or A rrs after ral Dire									·				
	To the Hospital or Attending Physician: Within 24 hours after death.  To the Funaral Director: After this certification and the funaral Director: After this certification in by the funaral director, the funaral director.	Medical	29a. Certifier (Check only one) Certifier 2 Medic	ying Physicien: To the al Examiner: On the ba and mann	sis of examinat	wledge, death tion and/or inv	occurred a restigation,	t the time in my opi	e, date and inion, deat	d place, ar h occurred	d due to the	cause(s) a date and	and manner as place, and due	stated. to the cause(s)
	To the I	Σ	29b. Signature and title of certi	fier			29c.	License		GG			signed (Monti	
1			1 -	Shan			7	2 4	170	00		10	2.01	1
			30. Name and address of person	•			,	a. 1.			1 00450			
	Sta	te	Dr. A. D. Shah, 31. Date filed (Month, Day, Yea	ar) 32.	dical Ar gistrar's Signat		Leon	ardto	wn, Ma	arylan	d 20650	2		
	Registr		DEC (	3 2004	La france d	1	Compression of the Compression o							

		_	For State Registrar	State of Maryland		artment of F		nd Me		20	04	39309
	Physici /Medio		Decedent's Name (First, Middle, La     Rossie Alma Wise						2. Date of Death Month Novembe	Day	Year 2004	3. Time of Death 8:50 P
	Examin		4a. Facility Name (If not institution, given Millennium Health	re street and number)  1 & Rehab. Center		4b. City, Town, o  Edgewate	er			Anne A	rund	lel County
	Funeral Director			6ex 1 ☐ M 2 ☐ F 7. Age (In yrs. last 89	Yrs.	If Under 1 Year Months Days	If Under 2	Min.	May 22,			place (State or Foreign htry) LESSEE
	he Maryland 28e-f show criffed at	Director	10a. State 10b. County	ndel Co. Edg	own or Lo	er				- China of M		0d. Inside City Limits 1 □ Yes 2X No
	with t	Dir		and.		10f. Zip Code 21037			10	g. Citizen of W $U_ullet S_ullet A_ullet$		ntry?
36	should be filed within 72 hours after death with the Maryland nd Mental Hygjene. • marked other than "neturel", or Items 23e or 28e-1 show umatic event, if a M-dical Examitar must be incitified at	by Funeral	144 Washington Ro	12. Was Decedent Ever in U.S. Armed Forces? 1  Yes 2 X No If Yes, Give Year or Dates:	1	Was Decedent of H If Yes, specify Cuba  1 Yes 2 No	lispanic Origi an, Mexican, Specify:	in? (Speci Puerto Ri	fy Yes or No- can, etc.)	14. Race Black		
Maryland 21215-0036	ithin 72 hou ie. ian "neture i Medical E	Completed 1	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation 1	6a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	ation during most o	of working	7	6b. Kind of Bu	siness/Ind	dustry
and 21	be filed staf Hygi od other event, I	Be	11 17. Father's Name (First, Middle, Lasi	UNK	Regi	istered N		's Name (	First, Middle, Ma	Health		
Maryl	ges 1 and 2 should it of Health and Men if item 27 is marke or other treumatic	ဥ	19a. Informant's Name/Relationship David Case (Sor			ng Address <i>(Street</i> Knight Ho				-		•
Baltimore,	Pages 1 ar	- Transmitter	20a. Method of Disposition  1 ABurial 2 Cremation 3 C  4 Donation 5 Other (Species	Jriginoval nom State		osition (Name of matory or other place Mem. Gard		loveni 20	ber 24,20 04 Da			e, Marylanc
Balti	permit. Page Department Importent: If any injury o		21. Signature of F	a la la la la la la la la la la la la la	2	2. Name and Addres	ss of Facility		Funeral	Home C	alve	ert, P.A.
	Physician /Medical		23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. A CUTE Coreh	rovo		5/945			st,		Approximate Interval Between Onset and Death I Week.
8760,	ate be executed by thysician and purial-transit and	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Phere consequent b. Due to (or as a consequent c. Due to (or as a consequent d	2 4 °C ( ce of):	Cardiovo	scu la	y c	liseas	e :		nore than 5 years
.O. Box 6	The law requires that the death certific thas been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1	ath 3[	□Ectopic pregnancy	,			23d. Date Mon		ry Day Year
0	quires that to in signed by uld be detac		Parll. Other significant conditions  Hyperten 17 ve	contributing to death but not resultin	g in the u	nderlying cause giv	en in Part I.			_	bute to th	abiy 4 (90nknown
Division of Vital Records,		Completed by	Recurrent Peripheral	Congestive H	ear		lw7e	•	24a. Was an autopsy performe	ed? de	/ere autorior to coreath?	osy findings available inpletion of cause of
Vita	sicien: certifii rector,	Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:		Oth	-		Check only one			SAME SE
ion of	ding h. Afte fune	atlon; To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	b. Time o Injury	f 28c. Injun Worl	4 🗀 Nurs	28	5 ☐ Residen d. Describe how			"
Divis	itel or Attendirs after death. sel Director: A	Certification;	3 Suicide 6 Could not be determined		, farm, str	reet, factory, office		28	f. Location (Stre City or Town,	et and Numbe State)	r or Rura	l Route Number,
	To the Hospitel or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Exa	nysician: To the best of my knowled miner: On the basis of examination and manner stated.	dge, deat and/or in	h occurred at the tin vestigation, in my o	pinion, death	place, and occurred	at the time, date	e and place, a	nd due to	the cause(s)
	vit To	-	29b. Signature and title of certifier	· Surana.		D 5	065	3		d. Date signed		
	3		30. Name and address of person who 5851 - Dea	completed cause of death (Item 23)	а) (Туре, Ноил	Print) GYA		cale	419月入		751	3
	Sta Registr		at Date (C. 1.04 and Date Manual	4 2004 Maries	K			,	•			

			1 - For State Registrar	State of Maryla	and / Depa	artment of F	lealth and I	Mental Hygi	ene	20210
			Hegistrar  1. Decedent's Name (First, Middle.)	Last)		rincate or	Dealii	2. Date of Death	a. NB. 004	3 9 3 0
	Physici		Cecil Ogbern W	Hilliama				Month	Day Year	
	/Medio Examin		4a. Facility Name (If not institution,			4b. City, Town, o	r Location of Death		18, 2004 4c. County of Death	
			Charlotte Hall V	eterans Home		Charlott	te Hall		St. Mary's	s County
	Funeral				s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		place (State or Foreign intry)
	Director		577-07-1290 Usual Residence of Decedent	91	Yrs.			Jan. 24.	1913 Nort	th Carolina
	land ow		10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	Mary Ing	ţō	Maryland Calver	et County F	unkirk					1 ☐ Yes 2 X No
	h the	Funeral Director	10e. Street and Number	t county   D	MINITIN	10f. Zip Code		10	g. Citizen of What Cou	intry?
	th will	aiD	9905 Greening C	ourt		20754			U.S.A.	
	r dea	ne	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sa an, Mexican, Puerto	pecify Yes or No-	14. Race - Ameri Black, White	
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Marrie 3 🎞 Widowed 4 ☐ Divorced	If Yes, Give	1	1 ☐ Yes 2 X No		, ,	Specify: Whi	
21215-0036	within 72 hours after death with the Maryland ene. than "netural", or Iteme 23e or 28e-1 show the M. Jical ExInter ribet be ricillised at	ed t	15. Decedent's	Year or Dates:	16a Dece	dent's Usuai Occup	ation	1	6b. Kind of Business/Ir	
215	in 72 ho n "netur M. dical	piet	(Specify only highest	grade completed)	(Give	kind of work done of DO NOT use retired	during most of world	king	DD. KING OF BUSINESS/II	loustry
212	d with giene gr tha	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Insu	rance Age	ent	٦	Insurance C	Company
bu	al Hy d other	BeC	17. Father's Name (First, Middle, La	.st)				ne (First, Middle, Ma		only only
yla	Ment Ment arked atlc s	2	Sammie Hillard	Williams				ce White		
Maryland	2 short and is m		19a. Informant's Name/Relationship						City or Town, State, Zij	
	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: if I tem 27 is marked other than any injury or other treumatic svent, It a Magnes.		Cecilia A. Marti		The second secon				Maryland 2	
Baltimore,	ages nt of h :: if ltc		1 KBurial 2 ☐ Cremation 3			natory or other place		per 27,	oc. Location - City or T	
탶	artme orteni injury		'4 ☐Donation 5 ☐ Other (Special Signature of Fu	ony) Re		ion Cemet			linton, Ma Home Calve	ryland
Ba	permi Depa Impo any ir		Michael	1664					, Owings,	
E			23a. Part1. Enter the disease, or co	omplications that caused the de						Approximate
	Pnysician		shock, or heart failure. List or Immediate Cause (Final	ity one cause on each line.	101	inst.	retion			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a Due to (or is a cons	equence of):	JVIJA	01100			
	Examiner		Sequentially list conditions	b						
	pg ti	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	equence of):					
	and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse	aguanco of):					
8760,	cate be executed physicien and the burial-transit	icai E		540 (0) 23 2 00/13	oquance or).					
687	ficate p physics ts the			d						
Вох	eath certific attending p	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg		41.1.5.700	·		23d. Date of delive	erv
	death e atte	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of		Ectopic pregnancy Other (specify)			Month	Day Year
P.0.	at the by th	hys	9 Unknown	9□ Unknown						
	The law requires that the death certifics ate has been signed by the attending pt page 2 should be detached for use as t	þ	Part II. Other significant condition	s contributing to death but not re	Z).	_	en in Part I.		cco use contribute to the	
Vital Records,	w requir been si should	Completed	LONOVIAVO	avievy	CVIZE	ease_		1 🗆 Yes	2 No 3 Prot	pably 4 Hinknown
lec	e law has b je 2 sh	nple	Congestin	e nearT,	Tall	ure		24a. Was an autopsy	prior to co	psy findings available mpletion of cause of
<u>=</u>			Drabetes	Mellitu	5			performe		2 🗆 No
Vit.	ding Phyeicien: The h. h. After this certificate ha funeral director, page	Be	25. Was case referred to medical examiner?	Hospital:		Othe		h (Check only one)	-	
of	Phys rthis ral di	5. To	1 Yes 2 No 27. Manne of Death	1 Inpatient 2		IL 3 DOA	4 Nursing Ho	ome 5 Resident 28d. Describe how	ce 6 ☐Other (Specify	y)
Division	Attending Physicien: r death. sctor: After this certifict by the funeral director,	tion	1 Valural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date of Injury (Month, Day Year)	Injury	Work	(?` Yes 2 □ No	Edd. Describe new	injury occurred	
<u>N</u>	r Attend er death rector: / by the f	ifica	3 Suicide 6 Could no	t be	home, farm, str	eet, factory, office	100	28f. Location (Street	et and Number or Rura	l Route Number,
á	s afte	Certification;	4  Homicide	building, etc. (Spec	cify)			City or Town,	State)	
	lospii hour uner		29a. Certifier 1 Certifying	Physician: To the best of my ki aminer: On the basis of examin	nowledge, death	occurred at the tim	e, date and place,	and due to the caused at the time, date	se(s) and manner as s	tated.
	To the Hospitel or Attend within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical	one,	and manner stated.						
ł	To To		29b. Signature and title of certifier			29c. License	number	7_ 29d	. Date signed (Month,	Day, Year)
						Doo	2009	T	11-15	0004
2	0+1		30 Name and address of person wh	o completed cause of death (Ite	em 23a) (Typie,	Spot OV	W. Pu	on o Fro	denov	mx66FP
Ĭ	Sta	te	31. Date filed (Month, Day, Year)	32. Registra s Sign	nature	Jan			acrucy)	77.0
	Registra		NOV	2 3 2004 Dise	w St.	Sperke				

			For 1_ State	State of Maryla		ent of Health and	Mental Hygier		000
			Registrar	<del>.</del>	Certific	ate of Death	Reg. I	10.2UU4	39311
	Physic: /Medi		1. Decedent's Name (First, Middle, Las	Jones	Wh	ite	2. Date of Death Month	Day Year	3. Time of Death 0 7:00 A.M
	Examir	er	4a. Facility Name (If not institution, give	street and number)	100 PO	City, Town, or Location of Dea	ith	County of Death	4
	Funeral Director		5. Social Security Number 6. Sec. 216-16-7896	x	s. last birthday) If Ui Yrs. Mon	nder 1 Year   If Under 24 Hr ths Days Hours Mir		9. Birth	place (State or Foreign
Ī	anyland ehow	_	Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or Location	0.11			0d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show rman be rediffed at	Director	10e. Street and Number	ter 10	comoke	Zip Code	10g. (	itizen of What Cour	1 DYYes 2 □ No
	death wii ms 23a c	eral D	214 11th 54	12. Was Decedent Ever in	110 112 110 0	21851		U.S.A.	
36		by Funeral	11. Marital Status  1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 W No If Yes, Give	If Yes,	ecedent of Hispanic Origin? ( specify Cuban, Mexican, Pue s 2 <b>12</b> 7No <i>Specify:</i>	rto Rican, etc.)	14. Race - Americ Black, White, Specify: 1	etc.
5-00	72 hou natura iical E	eted b	3  Widowed 4 □ Divorced  15. Decedent's Edi (Specify only highest graves)	Year or Dates:	16a. Decedent's t	/	ndring 16b.	Kind of Business/In	ack dustry
2121	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	HOUS:	T use retired)		self	
Maryland 21215-0036	should be filed nd Mental Hygin markad othar imatic event, L	To Be C	17. Father's Name (First, Middle, Last)	Jones			me (First, Middle, Maide		
ary	and M and M Is mar	-	19a. Informant's Name/Relationship (T		19b. Mailing Add	ress (Street and Number or F			Code)
	is 1 and 2 should of Health and Men item 27 is marka other traumatic		Wendell Wh 20a_Mothod of Disposition	ite grando	Place of Disposition (cemetery, crematory)	th Street	Pocomoki Date 20c.	Location - City or To	nd. 2(85)
Baltimore,	Pages nent of ant: If it		1 Burial 2 Cremation 3 1 1 4 Donation 6 Other (Specify,	tomotar main otato	+ Singi C	or other place)		oneko 1	
Balt	permit. Pages Department of Important: If i any injury or		21. Signature of Furieral Service Licens	fal.	BOUN	and Address Facility	veral Home	md. 218	
			23a. Part1. Enter the disease, or comp shock, or heart allure. List only of	lications that caused the deane cause on each line.	ath. Do not enter the r	node of dying, such as cardia		2. 4. 6	Approximate Interval Between
	Physician /Medical		Immediate Cause (Fihal disease or condition resulting in death)	a. Due to (or as a conse	entia	-			Onset and Death
	Examiner		Sequentially list conditions,	b					
ī	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Clisease or injury that initiated events	Due to (or as a conse	quence of):				
8760,	ate be executed obysician and the burial-transit	ŭ	resulting in death) Last	Due to (or as a conse	quence of):				
9		fedicai		d	-				
O. Box	ne death certificate be ex the attending physician thed for use as the buria	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3 □Ectopi	c pregnancy (specify)		23d. Date of delive Month	ry Day Year
s, P.O.	requires that the deen signed by the	by Ph	Part II. Other significant conditions co	ntributing to death but not re	sulting in the underlyin	g cause given in Part I.	23e. Did tobacco	use contribute to th	e cause of death?
Records,		eted	- W. B				-	Proba	ably 4 Unknown
Il Rec	The la ate has page 2	Сошр			<del></del>		24a. Was an autopsy performed? 1 ☐ Yes 2 🗷 N	prior to con death?	sy findings available on the state of the st
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:		0+	ath (Check only one)		
Division of Vital	To the Hospital or Attanding Physician: within 24 hours after deals are this certific completely filled in by the funeral director.	Ilon: To	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 28b. Time of Injury M	DOA Other: 4 ExNursing I	dome 5 Residence 28d. Describe how inju		)
Jivisi	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury · At h building, etc. (Speci		-	28f. Location (Street a City or Town, Stat	nd Number or Rural e)	Route Number,
_	Hospital 24 hours Funeral tely filled	Medical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medicel Exami	ner: On the basis of examina	owledge, death occurr ation and/or investigat	ed at the time, date and place ion, in my opinion, death occu	a, and due to the cause(s urred at the time, date an	s) and manner as sta d place, and due to	ited. the cause(s)
	o the	Mec	29b. Signature and title of certifier	and manner stated.		29c. License number	29d. Da	ite signed (Month, D	Pay, Year)
	. , , , ,		) (Davis	P, MD		D54422	_	11-270	4
ET	12		30. Name and address of person who co	empleted cause of death (Itel	m 23a) (Type, Print)	Pownok	ce; MD	21851	1
	State Registrar  31. Date filed (Month, Day, Year)  32. Registrar's Signature								

			For 1 = State Registrar	,,,,,	State of		d / Depa		t of H	ealth a		lental Hy	_	04	39:	312
	Dhunia		1. Decedent's Name (First, M		,	_						2. Date of De Month		Year	3. Time	of Death
	Physic /Medi		Catherine Lo				rews	,	e (c.			Decemb		004	9:56	a M
	Exami	ner	4a. Facility Name (If not institute 811 Fairfie			per)				Location o			4c. Count	y of Death Carre		
	Funeral		5. Social Security Number	6. S	ex 7	. Age (In yrs.	last birthday)			If Under		8. Date of Bir (Month, Da	th W Yearl	9. Birth	place (State intry)	or Foreign
	Director		220-22-4685	<u> </u>	□M 2 <b>X</b> F	85	Yrs.	Months	Days	Hours	Min.	Oct. 25	1919	Mar	yland	
	and and		Usual Residence of Deceden			10c. City	y, Town or Lo	cation							10d. Inside (	City Limits
	e Mary	ctor	Maryland Anr	e Ar	rundel	G	len Bu	ırnie								s 2 XNo
	th with th	Funeral Director	10e. Street and Number 603 Tranton F	oad				10f. Zip 210	Code 061				10g. Citizen of United			
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "neturel", or items 23e or 28e-f show amy injury or other treumetic event, the Medical Eventire russible hollified at any injury or other treumetic event, the Medical Eventire russible hollified at ances.	b	11. Marital Status 1 ☐ Never Married 2 ☐ № 3 ☑ Widowed 4 ☐ Divor		12. Was Deced Armed Forc 1 ☐ Yes 2 If Yes, Give Year or Dat	es? ⊠No		Was Deced If Yes, spec 1 ☐ Yes 2		spanic Ori n, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	- 14. Ra Bla Speci	ck, White	ican Indian, , etc. Vhite	
15-0	in 72 h i "netu ledical	Completed	15. Dece (Specify only hi	hest gra	ducation de completed)		16a. Dece (Give life.	dent's Usua kind of wor	l Occupa k done d	ition u <i>ring m</i> osi	t of worki	ng	16b. Kind of E	Business/I	ndustry	
212	giene. er then "	Somp	Elementary/Secondary (0-1	2)	College (1-4	or 5+)		ome M					Own	Home		
Maryland	nould be filed it Mental Hygi harked other netic event, I	To Be (	17. Father's Name (First, Mide Phillip O. Jo										Maiden Suma th Driv			
	alth and to the street of the		19a. Informant's Name/Relation Charles C. An										er, City or Town			
Baltimore,	Pages 1 a ent of He nt: If item ry or othe	9	20a. Method of Disposition 1 □ Surial 2 □ Cremati 4 □ Donation 5 □ Othe				lace of Dispo emetery, crer udon P	sition (Nam natory or of	ne of ther place	9)	C	ate	20c. Location Baltim	- City or T	own, State	
Balti	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Serv		·		22	2. Name and	d Addres	s of Facilit	y Hu	ibbard I	Funeral	Home	, Inc.	
	6		23a. Part1. Enter the disease shock, or heart failure.	or com	ulications that cau	sed the death							rest,	waryı	Approxima Interval Be	ate
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	only only	aDue to (or	She	mer	16	200	en	u		Disea	-	Onset and	l Death
760,	xate be executed xxx xxx xxx xxx xxx xxx xxx xxx xxx x	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Joseans of Impury that initiated events resulting in death) Last	{	c	as a consequ		wh	u	Va.	en	les R	Jislev	re	25%	<u>n</u>
P.O. Box 68	The law requires that the death certifica ate has been signed by the attending phage 2 should be detached for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown			h 2∏Fetal It at time of de	death 3	Ectopic pre						ate of delive	,	Year
rds, F	juires tha n signed   Ild be det	by	Part II. Other significant con-	litions c	ontributing to dea	th but not resu	ılting in the uı	nderlying ca	ause give	n in Part I.		23e. Did to	obacco use con res 2 <b>X</b> No		he cause of Dably 4	
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a	n: Th licate r, pag											1 Yes		1 🗌 Yes	2 🗆 No	
Vital	sicle certi	o Be	25. Was case referred to med examiner?  1  Yes 2 No	icali	Hospital:		FB/0-1		Othe	r		(Check only of			Acci	sted
n of	ding Physicien: The n. After this certificate ha funeral director, page	on: To	27. Manner of Death	dina	1 ☐ Inp 28a. Date of (Month,		ER/Outpatien 28b. Time of Injury		Bc. Injury Work	4 LI NUI		ne 5 Resid	lence 6 k2 Oth	ner <i>(Speci</i> i red	Livi	
Division	or Attendi after death. Director: A in by the fu	ficati	2 Accident inv	stigation		Injury - At ho	me farm str	M eet factory		es 2□N	-	98f Location /S	Street and Numi	er or Rus	al Route Nur	pher
Ο̈́	tel or A rs after el Direc ed in by	Certification;	4  Homicide det	benimed		, etc. (Specify		oot, lactory,	Omoo			City or Tow	in, State)	Jer or right	ar modie radii	1001,
	To the Hospital or Attending Physicien: within 24 hours after death as a start death in sortification the funerel Director: After this certification in the funeral director; it	Medical	29a. Certifier 1 Certi (Check only one) 2 Medi	ying Ph al Exan	ysician: To the bas niner: On the bas and manne	is of examinat	wledge, death ion and/or inv	occurred a restigation,	at the time in my opi	e, date and inion, deat	d place, a	and due to the ded at the time, o	cause(s) and made,	anner as s and due t	tated. the cause(	s)
1	To the vithin of the comple	W	29b. Signature and title of cer	ifier 7	nddli	tn		29c.	License	number 44	3		29d. Date signe	d (Month,	pay, Year) 2014	,
1	('		John W. N	on who	d lo Lo	of death (Item	23a) (Type, Pan	Print)	Porce	e v	Vert	MA 57	for 7	ムカ	2115	7
	Sta		31. Date filed (Month, Day, Ye			istrar's Signat	ure		. ~~	1	6	7 ( 1)	()	-10	- 10	<i></i>
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			For State Registrar	State of M	aryland /	-	artmen rtificate					Reg. N	71101.	393	313
	Physici		Decedent's Name (First, Middle, Last     Hildra Karan		n						Date of De Month Decem		<sup>y</sup> 9 , 2ੴ	3. Time of 2:3	of Death O PM
	/Medio Examin		4a. Fecility Name (If not institution, give	street and number)			4b. City,	Town, or	Location	of Death	-	40	. County of Dea		
1			Joseph Richey	Hospic	е				imor				N/		
	Funeral Director		2.0 00 .000	x 7. Ag ☐ M 2☐ F	ge (In yrs. last	birthday) Yrs.	If Under Months		If Under Hours	Min.	Date of Bir (Month, Da July2	2 , 1	9.8ir 938 N.	thplace (State ountry) Caro	or Foreign lina
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Lo	cation							10d. Inside (	City Limits
	Many i-f sh	ţō	Maryland N/A				Balt	imo	re					¹ <b>X</b> Yes	s 2□No
	n the	rec	10e. Street and Number		1		10f. Zip			~		10g. Ci	tizen of What Co	ountry?	
	th wit	aiD	3009 Lyttleton	Road				2	1216				USA	/	
36	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23s or 28s-f show any Injury or other treumatic event, the Medical Examiner must be notified at angles.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1  Yes 2 If Yes, Give Year or Dates:	)		Was Deced if Yes, spec 1 ☐ Yes		ispanic Or n, Mexical Specify:		fy Yes or No can, etc.)	)-	14. Race - Ame Black, White Specify: B		
Š	2 hou	ted	15. Decedent's Ed		1	6a. Dece	dent's Usua	I Occupa	ation	t of working		16b. K	(ind of Business	/Industry	
215-0036	thin 7 e. en "n	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT us	e retired	)					0 -	7 - b
21	filed wil Hygien other th	5	9th Grade			Foo	d Se	rvio		orker			timore	Co. N	scnoo
Maryland	ould be file Mental Hy arked oth	To Be	17. Father's Name (First, Middle, Last) Henry Buck								First, Middle,		lliams		
Mary	end 2 should salth and Men n 27 Is marke ser treumatic		19a. Informant's Name/Relationship (7  James H. Alderm										or Town, State, .		
ē,	s 1 er f Hea item othe		20a. Method of Disposition		come	of Dispo	sition (Nan	ne of ther place	e) 1	2/16ª	04	20c. L	ocation - City or	Town, State	
Ë	Pages nent of I ant: If its ury or o		1 Burial 2 □ Cremation 3 □  '4 □ Donation 5 □ Other (Specify)							tery		Tab	or Cit	у, ус	
Baltimore,	permit. Departm Importe any Inju		21. Signature of Funeral Service Licens	ams	·		2. Name an <b>240</b>			OILU			rris F altimo		
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that cause ne cause on each I	d the death. D	o not ent	er the mod	e of dying	g, such as	cardiac or r	espiratory a	rrest,		Approxima Interval Be	etween
	Physician		Immediate Cause (Final disease or condition		mall c	ex lu	ing i	CANO	ces					mon-	Death LS
	/Medical		resulting in death)	Due to (or as	a consequen	ce of):									
	Examiner		Sequentially list conditions, if any, leading to immediate	b											
	be is	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequen	ce of):									
	cate be executed physicien and the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequen	ce of):									
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687	ficate phys	edic		d											
.O. Box (	The law requires that the death certificate be executed tte has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Mo	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal de	ath 3□	Ectopic pro Other (sp		- 12-1				23d. Date of de Month	livery Day	Year
٩	that hed by deta		Part II. Other significant conditions co	ntributing to death t	out not resultin	g in the u	nderlying c	ause give	en in Part I		23e. Did t	obacco	use contribute to	the cause of	death?
ds	puires n sign ald be	d by									10	Yes 2	□No 3万P	robably 4	]Unknown
Records,	s been si should	Completed									24a. Was			utopsy findings	
Be	The lay te has age 2	E O									autor perfo	ormed2	death?	completion of	cause of
Vital	ician: Th certificate rector, pag	(a)	25. Was case referred to medical						26. Place	e of Death (	Check only o			1	
f∨	Physician: this certificatal director,	ToB	examiner? 1 □ Yes 2 No	Hospital: 1 ☐ Inpati	ent 2□ER/	Outpatier	nt 3 DC	Othe	er: 4 □ Ni	ursing Home	5 🗆 Resi	dence	6 Other (Spe	ocity) Hos	حت أم
n of	ding Physician: The h. After this certificate ha funeral director, page		27. Manner of Death  1 ■ Natural 5 ■ Pending	28a. Date of Inju (Month, Da	ury 28 ay Year)	b. Time o Injury		8c. Injury Work			d. Describe	how inju	ry occurred		
Division	or Attending uter death. Director: After in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be				М		Yes 2 🗆		f l sestion (	C44-	- d More borne - O	- I D A Al-	
ĭ <u>&gt;</u>	or Att	T.	4 Homicide determined	28e. Place of In building, e	jury - At home tc. <i>(Specify)</i>	, farm, str	eet, factory	, office		281	City or To	wn, Stati	nd Number or R e)	urai Houte ivui	nber,
	To the Hospital or Attent within 24 hours after death To the Funerel Director; completely filled in by the	Medical Ce		vsicien: To the best iner: On the basis of and manner si	of examination										(s)
	o ths ithin i o the emple	Med	29b. Signature and title of certifier	and mailiner 5			290	License	e number			29d. Da	ite signed (Moni	th, Day, Year)	
	F≩Fö		\$ 5/4. IM				D	24	170			D	ecember	9 200	4
	(h)		30. Name and address of person who	ompleted cause of	death (Item 23	. 1	Print)		CL	R. II	2000	. N	1D 21	201	1
	V CV		31. Date filed (Month, Day, Year)	HOSPICE 32. Regist	rar's Signature		Enta	no j	>	WOLLT	14-104		- 5 4-1	- 1	
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1016 MI

Hilda Aldaman

			1 - For Amend Item	State of 1 25 per Ve	Marylan rb.,G8	d / Depa	rtment	of He	ealth a eath	ınd M	lental Hyg	giene	001	4 (	39314
	Physici	an	1. Decedent's Name (First, Middle, La		Budd						2. Date of Dea		/ 000 Ye	ear	3. Time of Death 11:42 p <sup>M</sup>
	/Medic Examir		4a. Facility Name (If not institution, given Holy Cross Hosp	ve street and numb					ocation o		12		County of t		<u> </u>
	Funeral Director		,	Sex 7. 1 □ M 2 1 F	Age (In yrs. 75	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birtl (Month, Day 03-20-1	929		Countr	ce (State or Foreign y) • Maryland
	Maryland a-f show	tor	10a. State 10b. County  Md . P . G	•	10c. Cit	y, Town or Lo			-					100	d. Inside City Limits 1 XYes 2 No
	h with the 23a or 28a	ai Director	10e. Street and Number 14103 Bramble La	ne #T <b>-</b> 3			10f. Zip	Code 207	708			10g. Cit	izen of Wha		y?
980	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show te Medical Examirier must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decede Armed Force 1 Tes 2 If Yes, Give Year or Date	es? DXNo	1	Vas Deced f Yes, spec		panic Orig , Mexican, Specify:	in? (Spe Puerto	ecify Yes or No- Rican, etc.)		14. Race - A Black, V Specify:	White, et	c.
Baltimore, Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Mental Hygene. Is marked other than "natural" or items 23s or 28s-f show aumatic event, the Medical Examinatment to notified at	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12th	ade completed) College (1-4	or 5+)	16a. Deced (Give life. L	kind of wor DO NOT us	k done du e retired) Medic	ring most	Aide		Fa: Nu:	nd of Busin Irland Ising	1	•
yland	ould be fil Mental H arked ott atic even	To Be	17. Father's Name (First, Middle, Last Preston Holland						Ber	nice	Gaines				
, Mar	ges 1 and 2 should t of Health and Men If item 27 is marke or other traumatic		19a. Informant's Name/Relationship Diane L. Calhoun							0782	I Route Numbe	r, City o	r Town, Sta	te, Zip C	Code)
imore	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		20a. Method of Disposition  1		יו פוג	lace of Dispo emetery, cren Mem •				2 <del>-</del> 1.			dy Sp		n, State
Balt	permit. Departr Imports any inj		21. Signature of Funeral Service Lice	Bacon, C	C 34						Pacon Wash.,	Fune	eral E	Iome	, Inc.
	Pnysician /Medical		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on eac Acute	h line. Myoca	ardial				cardiac o	r respiratory arr	rest,		li C	Approximate Interval Between Conset and Death I hour
8760,	Examiner	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Ather	as a consequence of as a consequence as a consequence as a consequence of	rotic (	Cardio	ovasc	ular	Dis	ease				) years
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		n 2 ∏ Fetal tat time of de	Ideath 3	Ectopic pre					4	23d. Date of Month	,	ay Year
	w requires that I been signed by should be deta	by	Part II. Other significant conditions Brain Stem Strok					use giver	in Part I.			bacco u es 2[			cause of death?
Il Records,		Completed									24a. Was a autops perfori 1X Yes	SV	24b. Were prior death	to comp	y findings available iletion of cause of
n of Vital	ng Physician: Th fter this certificate neral director, pag	To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Magner of Death 1 Anatural 5 Pending	Hospital: 1 lnp		ER/Outpatien 28b. Time of Injury		Other	4 <b>∑</b> Nur.	sing Hor	Check onl on ne 5 \to Reside	ence 6		Specify)	
Division of	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral.	Certification:	2 Accident investigation 3 Suicide 6 Could not to determined	28e. Place of	Injury - At ho	ome, farm, stre	M eet, factory,		es 2□N	_	28f. Location (Si City or Town		d Number o	r Rural R	Route Number,
	the Hospital hin 24 hours a the Funeral C npletely filled	edical C	29a. Certifier (Check only one)  1 Certifying Pi 2 Medical Exa	hysician: To the be miner: On the basi and manner	s of examinal	wledge, death tion and/or inv	occurred a restigation,	t the time in my opir	, date and nion, death	place, a	and due to the cared at the time, d	ause(s) ate and	and manne place, and	r as state due to th	ed. e cause(s)
)	To the within 2 To the Complete	Me	29b. Signature and title of certifier	adhoe	ferre	n.M.5	- 1	License	576	30			signed (M		
_			30. Name and address of person who Anuradha Aru			10301 (Type,		ia Av	zenue	S	Silver S			-	
	Sta Registr		31. Date filed (Month, Day, Year) DEC 1 3 200		istrar's Signa	ture	Spor	Kr							

State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Annie Bentley 9:15A December 12, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince Georges 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthpface (State or Foreign Country) **Funeral** Days Months 1 □ M 2 □ F 245-20-6232 78 Director Nov.8,1926 North Carolina Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show Item 27 is marked other then "neturel", or items 23e or 28e-f show other treumetic event, the Medical Examinar must be inclined at Maryland Prince Georges Capital Heights Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4217 Shell Street 20743 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: Black þ 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 7: th and Mental Hygiene. 7 is marked other then "n. Elementary/Secondary (0-12) College (1-4or 5+) U.S.Govt 12 Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Morton Ora Ann Hines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s of Health an Richard W.BentleyJr. son 4217 Shell Street Capital Heights, Md20743 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 permit. Pages Department of Importent: If It eny injury or o 1 Burial 2 Cremation 3 Removal from State 12/18/04 Bethel Cemetery Rethel, North Carolina ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Chinn Funeral Service 22206 2605 S.Shirlington Road Arlington Va 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Acute Cerebrovascular accident Unknown /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.O. the 9☐ Unknown 9 Unknown ģ Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Jas autopsy performed? certificate of Vital 1 Yes 2 No 1 Yes 2 ₹No the Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death Check onl one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🗹 No J<sub>o</sub> this 28a. Date of fnjury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Division 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 124 hours at 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Rate For Ma 12.12.04 043446 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Georgia Avesuit 3.41 Silverspring MD 20902 FARAHIFAR ROINTAN MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 1 3 2004 Registrar

			State of Maryland / I	Department of Health and	Mental Hy	giene 👝 🦰	11 00016
				Certificate of Death		Reg. No. U	39316
			1. Decedent's Name (First, Middle, Last)		2. Date of De		3. Time of Death
	Physici		Leah Tenea Boone		Month 12	Day 5	Year 2:45 PM
1	/Medi Examir		4a Fecility Name (If not institution, give street and number)	4b. City, Town, or	Location of Death		
	_xam.		University of Maryland Med	ical Center Baltin	ware	Balt	more City
46	Funeral	(	5. Social Security Number 6. Sex 7. Age (In yrs. last bit	rthday) If Under 1 Year If Under 24 Hrs	8. Date of Birt	h	9. Birthplace (State or Foreign
	Director		216-69-2263 1□M 2\1 F	Yrs. Months Days Hours Min	(Month, Da	y, Year)	Country)
	_	١.	Usuel Residence of Decedent				MD
	ylan		10a. State 10b. County 10c. City, Tow	n or Location			10d. Inside City Limits
	Mar	Director	MD NA Balt	imore			.XXYes 2□No
	r 28	ě	10e. Street and Number	10f. Zip Code		10g. Citizen of V	Vhat Country?
	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 23s-1 show its Madical Examiner must be notited at	Ī	2020 Channan Duine	03.03.0			
	ms 2	Funerai	3839 Shannon Drive  11. Marital Status  12. Was Decedent Ever in U,S.	21213  13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	U . S	e - American Indian,
	fter c	2	Armed Forces?  XXNever Married 2 ☐ Married 1 ☐ Yes 2 [X] No	If Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	Blac	ck, White, etc.
ង្ក	Lrs a	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 211 No Specify:		Specify	Black
ğ	2 hou	8	15. Decedent's Education 16a	. Decedent's Usual Occupation		16b. Kind of Bu	Isiness/Industry
2	7 4	piet	(Specify only highest grade completed)	(Give kind of work done during most of wo life. DO NOT use retired)	rking		<b>,</b>
7		E	Elementary/Secondary (0-12)  N/A  College (1-4or 5+)  N/A	N/A		N/	7
פ	Hyg Hyg	Be Completed	17. Father's Name (First, Middle, Last)		me (First, Middle,		
a	uld be filed Mental Hygi irked other itic event, I	To B	Deneld Deser-	. , .			<i>i</i>
Maryland 21215-0020	nari mari	F	Ronald Boone  19a. Informant's Name/Relationship (Type, Print)  19t	Lasne.  D. Mailing Address (Street and Number or R	le Wri		State Zin Code)
Š	d 2 strain train	- 9		839 Shannon Drive			
á,	1 an Heal em 2	11	20a. Method of Disposition 20b. Place o	f Disposition (Name of	Date		City or Town, State
ᅙ	nt of nt of it it		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemete	ry, crematory or other place)			-110-0000
Baltimore,	tant rant	- 4	4 Donation 5 Other (Specify) King	Memorial Park	12/11/	04 Rand	dallstown, Md
<u>a</u>	Depa Impo any Ir		21. Signature of Funeral Service Licensee	22. Name and Address of Facility March F/H West			
_	40 = # a		MINDUO O GRUPING	4300 Wabash Ave,	Balti	more,	Md 21215
			23a. Part1. Enter the disease, or complications that cause the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardia	or respiratory ar	rest,	Approximate Interval Between
1	Physician						Onset and Death
	/Medical		Immediate Cause (Final disease or condition resulting in death)  a. Cor pulma	phale			3 months
	Examiner		resulting in death)  Due to (or as a	consequence of):			10111011111
7	p #	Examiner	- Branchan	ulmonary Di	Splas	a	7 months
T	ficate be executed physician and as the bunal-transit	am B	Sequentially list conditions,  Due to (or as a	ulmonary Dy consequence of):			
Š,	e e exe		Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury	Prematur.	L- 1		8 months
09/89	ate b nysic he b	edlcai	that initiated events resulting in death) Last  Due to (or as a control of the co		- 4		37707113
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r Ö	w requires that the death certi been signed by the attending should be detached for use a	Physician/M			101	es 2 No	3 ☐ Probably 4 ☐ Unknown
Ś	gned be de	þ					,
Cord	en si ould				24a. Was a		24b. Were autopsy findings available prior to
ပ္ပ	lawre lasbe s2she	De			pomor	niou.	completion of cause of death?
ř	The la te ha	Completed			125.Y	es 2□No	1 □ Yes 2 No
VITAI	an: tifica tor, p	Bec	25. Was case referred to medical	26. Place of Dea	ath (Check only or		
=	ysicia s cer direc	To E	examiner? 1 ☐ Yes 2 ☑ No  Hospital: 1 ☑ Inpatient 2 ☐ ER/Ou	Other:	lome 5□Resid		r (Snecify)
0	erat erat		27. Manner of Death 28a. Date of Injury 28b. ]	Time of 28c. Injury at	28d. Describe h		
6	Aft.	읉	1 Natural 5 □ Pending (Month, Day Year) I 2 □ Accident investigation	njury Work? M 1 ☐ Yes 2 ☐ No			
DIVISION	Atter r dea octor	100	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa	rm, street, factory, office			er or Rural Route Number,
5	din din	Certification:	4 ☐ Homicide building, etc. (Specify)		City or Tow	n, State)	
	spita nours nora refite		29a. Certifier Certifying Physician: To the best of my knowledge	, death occurred et the time, date and plece	, and due to the c	ause(s) and mai	nner as stated.
	Fu Fu Petel	edicai	(Check only one) 2 Medical Examiner: On the basis of examination en and manner steted.	d/or investigation, in my opinion, death occu	rred at the time, d	ate and place, a	nd due to the cause(s)
	To the Hospital or Attending Physician: The law within 24 Hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	×	29b. Signature and title of certifier	29c. License number	2	9d. Date signed	(Month, Dey, Year)
			Para = 900 and for MO	D33573	7	promh	CG DAM
	_	H	30. Name and address of person who completed cause of death (Item 23a) (	(Type, Print)			er 6,2004
	1		Renee Ellen Fox MD Room No	5W68 22 South	Green	e Stre	et
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signatuse	1			
	Registra		MFC 1 3 2004 A	Sports			

State of Maryland / Department of Health and Mental Hygiene 004 1 - For Stete Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** December of artiscs **Howard Monroe Blevins** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DON C Havie 15 Hortord Citizen's Care Center If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□F Yrs Director 235-16-3655 06/26/1918 Virginia 86 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r then "naturel", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2X No Havre de Grace MD Harford Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21078 209 Hopkins Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 M Yes 2 □ No If Yes, Give Year or Dates: WW2 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Engineering Technician U.S. Government 8th permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other traumatic event, 9005s. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be **Burlie Davis** Edd Blevins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 106 Bayland Dr. #19, Havre de Grace, MD 21078 Hazel I. Blevins- Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Harford Mem. Grdns. 12/09/04 Aberdeen, MD 21. Signature of Funeral Service Licensee Mitchell-Smith Funeral Home, P.A. aune 123 S. Washington, Havre de Grace, MD 21078 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sep815 days Pnysician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying auto-gases of it is that initiated events resulting in death) Last Examiner Due to (or as a consequence of) ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Preumonia 1 Yes 2 No 3 Probably 4 X Inknown Completed page 2 should Asporation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Dementia this certificate 1 Yes 2 XNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No After this of funeral direction 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D43115 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Havre de Grace, MD, 615 Union Ane 31. Date filed (Month, DEC 1°3°2004 32. Registrar's Signature State 28 meres souks! Registrar

Blevins Howar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra 39318 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year `ala 19:15 M 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Medica Center Do 1/1/1/
If Under 1 Year If Under 24 Hrs.

Hours Min. Balhmore University of Maryland 7. Age (In yrs. last birthday)
70 Yrs. 5. Social Security Number 6. Sex 1∆rM 2 ☐ F 8. Date of Birth 6 / 25 / 19 34 **Funeral** 9. Birthplace (State or Foreign Days Months Hours 079-26-4535 NEWWYORK Director Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits other treumatic event, the Medical Examiner must be notified at Completed by Funeral Director BERKELEY HEDGESVILLE 1 Yes 2/No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 178 ARROWHEAD RIDGE Items 23e 25427 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 M Ves 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore. Maryland 21215-0036 ŏ 1 Yes 2 No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced "naturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) C.I.A. College (1-4or 5+) LOGISTIC OFFICER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental F GEORGE N. BOSTON MATILDA SMITH 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 ls any injury or other tree once. MARGARET BOSTON/WIFE 178 ARROWHEAD RIDGE, HEDGESVILLE, WV 25427 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State SMITHSBURG CREMATORY DEC. 1 D Burial 2 □ Cremation 3 □ Removal from State 2004 \* 4 ☐ Donation 5 ☐ Other (Specify) SMITHSBURG, MD 21. Signature of Funeral Service Licensee BROWN FUNERAL FLOWER P.O. BOX 821, 327 W. KING ST., MARTINSBURG, WV 25402 Diones Dailes 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Respirator disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Small Cell lung Cancer III -13 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) use as the burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 🗌 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐ Yes 2 ☐ No 1 Yes 2 25. Was case referred to medical 26. Place of Death Check onlone examiner' Other: 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After t 28d. Describe how injury occurred 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifiei to Tertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Au 4176435f 15100 Kemmer 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) er 9W,22 greene St Be[hmore MI) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 1 3 2004 Registrar

		•	1 - For State Registrar	State of M	aryland		artment of tificate o		nd Mental Hy	giene Reg. Nd.	2007	39319
	Physici	an	1. Decedent's Name (First, Middle, Last Isabelle Collier	,					2. Date of De Month Decemb	ath Day	2004	3. Time of Death 1:20 PM
	/Medio Examir		4a. Facility Name (If not institution, give		r)		4b. City, Town	, or Location of D			County of Death	1:20 PM
			Gilchrist  5. Social Security Number 6. Se		an /laura la		Tows		Hrs   a Data at B		Baltimo	
	Funeral Director			х ]м 21XTF /	ige (In yrs. Ia: 87	Yrs.	Months Day		Min. B. Date of Bit (Month Dec 30	y, Year	16 Mary	lace (State or Foreign Land
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation				1	0d. Inside City Limits
	h the Maryland r 28e-f show	ctor	MD		F	Baltim	ore					1  Yes 2□No
	th with th	Funeral Director	10e. Street and Number 2528 Foster Avenu				10f. Zip Code			10g. Citiz	zen of What Coun	itry?
	items 23a	nera	11. Marital Status	12. Was Deceden	t Ever in U.S.	. 13. \		L224 Hispanic Origin	? (Specify Yes or No Puerto Rican, etc.)	)- I	USA 14. Race - Amend	
920	a o	þ	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	Armed Forces 1 ☐ Yes 2 2 If Yes, Give Year or Dates			Yes, specify Ct		rueno Rican, etc.)		Black, White, Specify: Wh	etc. ite
5-0	"natural",	eted	15. Decedent's Edu (Specify only highest grad			(Give	lent's Usual Occ kind of work don	e during most of	f working	16b. Kir	nd of Business/Ind	dustry
21215-0036	e filed within all Hygiene. I other then "vent, Ir e Med	Completed	Elementary/Secondary (0-12)	College (1-4or	r 5+)		elf emp				liquor s	tore
nd	s 1 and 2 should be filed within f Health and Mental Hygiene. item 27 is marked other then other traumatic event, It.e M	Be	17. Father's Name (First, Middle, Last)						Name (First, Middle		Sumame)	
Maryland	2 should be 1 and Mental I is marked o raumatic eve	၉	George Gensler  19a. Informant's Name/Relationship (T)	rpe, Print)		19b. Mailin	a Address (Stre		ise Werne		Town State Zin	Code)
	1 and 2 : Health ar em 27 is		Douglas Collier/	son		2528	Foster		Baltimore		21224	
Baltimore,	Pages 1 ar		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F  4 ☑ Donation 5 ☐ Other (Specify)	Removal from State	con	ce of Dispo netery, cren	sition (Name of natory or other p	lace)	Date	20c. Loc	cation - City or To	wn, State
Balt	permit. Pages Department of Important: If i any injury or once.		21. Signa of Funeral Stylice Sicens	ade Di	ctor			ress of Facility tomy Boa MD 21	ard 655 W.	Ba1	timore S	treet
			23a. Part1. Enter the disease, or compleshock, or yeart failure. List only of	ications that cause ne cause on each	ed the death. line.					rrest,		Approximate Interval Between Onset and Death
	Priysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Al	zheu s a conseque	mes of	disea	5-2			L	1ears
Н	Examiner		Sequentially list conditions	o								
A	uted 1 Insit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a	s a conseque	nce of):						
, 0	ficate be executed physicien and is the burial-transit	Exa	that initiated events resulting in death) Last	Due to (or a	s a conseque	nce of):						
68760,	icate b physic s the b	edica		d								
Box (	certii ding		230. Was decedent pregnant	3c. If yes, outcom			Ectopic pregnan	cv		2	3d. Date of delive	*
P.O. B	the death y the atter iched for u	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown			Other (specify)				Month	Day Year
	res that the de igned by the a be detached f	by Ph	Part II. Other significant conditions con	ntributing to death	but not result	ing in the ur	derlying cause g	oven in Part I.		4		e cause of death?
ord	w requires been sign should be	eted						·	-	res 2		ably 4 🗍 Unknown
of Vital Records,	e la has	Completed							24a. Was autor perio 1 Yes		prior to con death?	osy findings available apletion of cause of 2 No
/ital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	1					Death (Check only o	-	1 103	Page 1
	ng Phys fter this meral di	on: To	1 Yes 2 No 27. Magner of Death 1 Natural 5 Pending	lospital: 1  lnpat 28a. Date of Inj (Month, D	jury 2	NOutpatient 8b. Time of Injury	28c. Inj	ury at ork?	ng Home 5 Resident	-	Other (Specify, oc. rred	HOSPICE
Division	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funerel	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		njury - At hom atc. <i>(Specify)</i>	e, farm, stre	M 1 [	Yes 2 No	28f. Location (S City or Tox		Number or Rural	Route Number,
O	spital o		29a. Certifier Certifying Phys	sician: To the bes	t al my knowl	edge death	occurred at the	time date and o	lace, and due to the	rause(s)	and manner as sta	ated
	the Ho in 24 h the Ful pletely	Medical	(Check on) 2 Medical Exami	ner: On the basis and manner s	of examinatio	n and/or inv	estigation, in my	opinion, death o	occurred at the time,	date and	place, and due to	the cause(s)
	with Com	2	29b. Signature and title of certifier	1	1006	) .	29c. Licer	nse number	77	29d. Date	signed (Month, E	Day, Year)
			30. Ame a waddress of person who co	empleted cause of	death (Item 2	7 (3a) (Type, I	Print)	2020	6601	NI CI	narles S	treet
			TINION CHA	LUFES, M	UD.						Md. 21:	
	Sta Registr	100	31. Date filed (Month, Day, Year)  DEC 1 3 2004		trar's Signatui مرهسمربر	B	porks	Arth				

State of Maryland / Department of Health and Mental Hygiene 39320 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 9:30 P M December 10 2004 EUGENE DAVIS /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner of Baltimore
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Baltimore Baltimore Hospita 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months 1XXM 2□ F 81 Director 217-24-8144 DEC 19 1922 VIRGÍNIA Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28e-f show other traumetic avent, the Medical Examiner must be nutified at XXYes 2 No Director BALTIMORE MARYLAND N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 21201 U.S.A. or Items 23a 1102 DRUID HILL AVENUE Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2**XX**No If Yes, Give Year or Dates: 1XX Never Married 2 Married 1 Yes 2XXNo Specify: Specify: BLACK þ 3 Widowed 4 Divorced "neturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Dep.riment of Health and Mental Hygiene. Important: If item 27 is marked other than "nr any njury or other traumetic event, the Mestil once. Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MARY F DAVIS unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 342 Bloom St. Apt 108, Baltimore, Maryland 21217 Mary Jones/Cousin Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State ARBUTUS MEMORIAL BALTIMORE, MARYLAND ' 4 ☐ Donation 5 ☐ Other (Specify) 12-15-04 21. Signaty e of Funeral/Service Licen 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE NUVan Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pne Physician umonia /Medical Due to (or as a consequence of): Examiner Farlure hronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed 2 No 2 No 1 Yes Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ■ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No 1 Inpatient the funeral dir this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Anatural 5 Pending investigation after death. М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely To the within 2 To tha 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier December 10, 2004 20056411 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 WBelvedere Ave Baltimore MD21215 KTonyaMason Hospital DIMAI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 3 Denne Registrar

21		For Amend Item 20a State Registrar  1. Decedent's Name (First, Middle, Last)	PERZZ PE	Hy TH	3 <b>683</b> 8	ertificate of	Health and Las Death	2. Date of Dea		00l <sub>4</sub>	3 9 3 2 3. Time of Death
Physician /Medical Examiner Funeral Director		Oklahoma Davis  4a. Facility Name (If not institution, give st  5. Social Security Number  166-42-1372	of Ba	/ / / / / / / / / / / / / / / / / / /		Be (†		December Death C. ty	4c. C	DOCY county of Death	nplace (State or Foreigntry) unk
a-f show lifted at		Usual Residence of Decedent  10a. State 10b. County  MD		10c. City	Town or Ba	Location 1.timore					10d. Inside City Limi
ath with the Mar s 23a or 28a-f sl rust be multified eral Director	3	3436 Auchentroly		#G4	2 4	10f. Zip Code	21217			USA	
burs after death value. critams 23a Examinat must	2	11. Marital Status unk 1: 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	<ol> <li>Was Decedent I Armed Forces?</li> <li>1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:</li> </ol>		unk	3. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☒ N		? (Specify Yes or No- uerto Rican, etc.)		I. Race - Amer Black, White Specify: b	
ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene.  If itam 27 Is marked other than "natural", or Itams 23a or 28a-f show or other traumatic avent, the Medical Examinat must be notified at or other traumatic avent, the Medical Examinat Instituted at To Be Completed by Funeral Director	and and	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) unk un1	completed) College (1-4or 5	+)	(G	cedent's Usual Occ ive kind of work don e. DO NOT use reti	e during most of	un un un	16b. Kind	d of Business/I	ndustry un
2 should be filed within and Mental Hygiene. Is marked other than aumatic avent. tha March and a Comp	ב	17. Father's Name (First, Middle, Last)		'		unk	18. Mother's	Name (First, Middle,	Maiden S	umame)	un
		19a. Informant's Name/Relationship <i>(Typ</i> SInai Hospital	e, Print)	1	240	)1 W. Bel	vedere A	r Rural Route Number	timor	e, MD 2	21215
Pages 1 ient of He nt: If itan ry or oth		20a. Method of Disposition  1	moval from State	C		sposition (Name of crematory or other pon Forest	37 1	Date 2-30-04	۰.	ation - City or 1 gs Mill	261
permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or other tra once.		21. Signature of Euneral Service License Ronal C	016.	ector		22. Name and Add State And Baltimore	ress of Facility	2-30-04 March F.H. 171 655 W. 1201 Balto	West	4300	Wabash Ave
Physician /Medical Examiner		23a. Pa 1. Enter the disease, or complic sho k, or heart failure. List only one limmediate Cause (Final disease or condition resulting in death)	ations that caused cause on each lir Due to (or as	10.		enter the mode of d  the So		rdiac or respiratory ar	rest,		Approximate Interval Between Onset and Death
ysician and e burial-transit cal Examiner	1	Sequentially list conditions, if any, teaching to immodule cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	2:00/180CU -+e~	ianica of):	7					20 years
The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit completed by Physician/Medical Examir	iyalcıdırımedi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	death	3 □Ectopic pregnar 5 □ Other (specify)			23	d. Date of delivership	very Day Year
ed by Pt	2	Part II. Other significant conditions cont	ributing to death b	ut not resu	ılting in th	e underlying cause (	given in Part I.	23e. Did to		/	the cause of death?
The lar	) _									prior to c death?	topsy findings availab ompletion of cause of 2 \sumbed No
Shys this al dii	2	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation	ospital: 1 / Inpatie 28a. Date of Injur (Month, Day	ry	ER/Outpa 28b. Tim Inju	e of 28c. In	Other: 4 Nursi	Death (Check only o	dence 6 [		ify)
To the Hospital or Attending Ph within 24 hours after death. To tha Funaral Diractor: After th completely filled in by the funeral Medical Certification: ]	Celtilica	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc.			street, factory, offic	е	28f. Location (S City or Tow		Number or Ru	ral Route Number,
he Hospi n 24 hour ha Funar pletely fill		29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one) 2 Medicel Examination (Check only one)		examinat	ion and/o	r investigation, in my	opinion, death	occurred at the time,	date and p	lace, and due	to the cause(s)
withir To th comp	IM	29b. Signature and title of certifier	2 MP			RE.	se number	Baltimo	29d. Date	signed (Month	Day, Year)
		30. Name and address of person who cor	npleted cause of d	eath (Item	23a) (Ty	De, Print)	deres.	Baltimo	KE.	MD.	3131.5
State		31. Date filed (Month, Day, Year) DEC 1 3 2004	32. Registra	ar's Signa	ture 4	1		NAT I JIM			

DHMH 17 Rev 1/2001

Oklehena Davis

Pt. Known CS

Oh		For State Registrar  1. Decedent's Name (First, Middle, L.	State of Masst)			rtificat			2. Date	Reg. N	10.2004	3 9 3 2 3. Time of Deat
Physicia /Medica Examine	al	I.ATHAN 4a. Facility Name (If not institution, gi	J. DRONE ve street and number)			4b. City,	Town, or	Location of		BER 28	Nay Year  3 , 2004  4c. County of Dea	4:00A
uneral Director			Sex 7. Ag	je (In yrs.	R last birthday) 74 Yrs.		LLVEI 1 Year Days	If Under 2 Hours	24 Hrs. 8. Date Min. (Mon	of Birth th, Day, Year 29,19	ONTGOME 9. Bit 930 Mur	RY thplace (State or Fore ountry) freesboro
28a-f show	Director	10a. State 10b. County  D.C.  10e. Street and Number			y, Town or Lo ashing		Code			10a. C	Citizen of What C	10d. Inside City Lim  1X Yes 2
al', or items 23e examinar must	by Funeral	1104 21ST. PI.AC  11. Marital Status  1  Never Married 2 Married 3  Widowed 4 Divorced	12. Was Decedent Armed Forces? 1  Yes 2 Yes, Give Year or Dates:			Was Dece	2000 dent of Hi cify Cuba	spanic Orig	in? (Specify Yes Puerto Rican, et	or No-	U.S.A.  14. Race - Am Black, Whi	erican Indian,
han "natura e Medical E	Completed	15. Decedent's Elementary/Secondary (0-12)		5+)	16a. Dece (Give life.		rk done d	lurina most	of working	16b.	Kind of Business	/Industry
d oth	To Be Co	12th 17. Father's Name (First, Middle, Las Russell Drone				Main		18. Mother  Esthe	's Name (First, A	diddle, Maide		<b>,</b>
am 27 thar t		19a. Informant's Name/Relationship  Maurice Hardy/s  20a. Method of Disposition		20h. P	733 C	Carso	n Ave		Oxon Hi	11, Md		
Important: If its any injury or of once.		1 Burial 2 Cremation 34 4 Donation 5 Other (Spec	ify)	C	emetery, cre crch Ce	matory or c	other plac <b>CV</b>	De	ec. 4,200	04 Co		
ysicia ne bur	ilcai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. METASTA Due to (or as  c. Due to (or as d.	a conseq	uence of):	NG ANI	) LIV	ER JU	INCTION			
attending p for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Feta	Ideath 3	⊒Ectopic p ⊒ Other (sµ		- 11 1 2			23d. Date of de Month	livery Day Year
be d	<u>م</u>	Part II. Other significant conditions	contributing to death b	ut not res	ulting in the u	inderlying o	ause give	n in Part I.	23e.			o the cause of death robably 4 💆 Unknown
page 2	Completed									Was an autopsy performed?	prior to	utopsy findings availa completion of cause 2 <b>X</b> No
	Be	25. Was case referred to medical examiner?	Hospital:				Othe		of Death (Check			
er th	ertification: To	1 Yes 2X No  27. Manner of Death 1 Xatural 5 Pending investigation	28a. Date of Inju (Month, Da		ER/Outpatier 28b. Time o Injury		28c. Injury Work	4 (23-1401)			6 □Other (Speury occurred	ocify)
<u>a</u> <u>a</u>	ပေ	3 Suicide 6 Could not determined	building, et	of my kno	y) wledge, deat	h occurred	at the tim	e, date and	City	or Town, Sta	(s) and manner as	ural Route Number,
ompletel	Medical	(Check only one) 2 Medicel Example 29b. Signature and title of certifier	miner: On the basis o and manner st	f examina	tion and/or in	vestigation	, in my op c. License	inion, death	n occurred at the	time, date a	ate signed (Mont	to the cause(s)
h		30. Name and address of person who	ellapalle completed cause of c	leath (Item	710 n 23a) (Type,	Print)	D006	1096		Dec	ember 2,	2004
Stat	e		completed cause of completed cause of completed cause of completed cause of complete cause of completed cause of	leath (Item ) 8 ar's Signa	609 Se	cond	Aver	ue #4	04B Si	lver S	pring,Md	1. 2091(

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Certificate of Death	Reg. No.2 0 0 1
	Dharaia		Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year
4	Physic /Medi		Roy Daniel	November 2, 2004 11:30 A
j	Exami		4a. Fecility Name (If not institution, give street and number)  4b. City, Town, or	
1			Heartland of Hyattsville Hyatt	sville Prince George's
	Funeral Director		5. Social Security Number 6. Sex 1 Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 1 Months Days Hours Min.	8. Date of Birth 9. Birthplace /State or Foreign
	pur *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	
	h the Marylar r 28e-f show	Funeral Director	MD Prince George's Hyattsville	10d. Inside City Limit
	or 28	ire	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
	23e	a	6500 Riggs Road 20783	USA
	ter dea Items	la e	11. Marital Status unk 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (S	specify Yes or No- 14. Race - American Indian,
020	ours af el', or Evern	6	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give Year or Dates:	b Rican, etc.)  Black, White, etc.  Specify: black
21215-0020	permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturet, any highy or other traumatic event, if a Medical Expone.	Be Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  unk  16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	unk 16b. Kind of Business/Industry $unk$
	d be filed antal Hyg ad other cevent,	Be C		me (First, Middle, Maiden Surname) un
Maryland	12 shoul n and Me is mark raumation	10		ural Route Number, City or Town, State, Zip Code)
e,	1 and Health Im 27 ther t		The state of the s	
Baltimore,	Pages ment of P ant: If ite ury or of		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Nother (Specify) in state	Date 20c. Location - City or Town, State
Balt	permit. Departimports any inj		21. Signature of Euneral Service Licensee Ronald S. Wards Virector State Anatomy Board	d 655 W. Baltimore Street
			Baltimore, MD 2120  23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	
)	Physician /Medical Examiner	ler	Immediate Cause (Final disease or condition resulting in death)  a. Human Immunodes Crency VIII  Due to (or as a consequence of):	Onset and Death
	executed n and al-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	
68/60,	The law requires that the death certificate be executed tte has been signed by the attending physician and page 2 should be detached for use as the bunal-transit	Medicai	resulting in death) Last  Due to (or as a consequence of):	
ROX	eath cer attendir I for use	Physiclan/	<b>d</b>	
л Э	res that the de signed by the a be detached i	hysi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of death
	that ned b	by P	Perpheral Vascular Visease	1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknow
or vital Records,	aw requires ts been sig 2 should b	Completed b	•	24a. Was an autopsy performed?  24b. Were autopsy findings available prior to completion of cause of death?
Ÿ	The la ate has page 2	E		1 Yes 2 No 1 Yes 2 No
<u> </u>		BeC	25. Was case referred to medical 26 Place of Deat	
>	Physician: rthis certificaral director,	ToB	examiner?	th (Check only one) ome 5 ☐ Residence 6 ☐ Other (Specify)
	Phy eral c		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe how injury occurred
<u> </u>	th. : After e funer	atio	1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No	
DIVISION	al or Attending s after death. I Director: After d in by the fune	Certification:	3 Suicide 6 Could not be	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or Attend within 24 hours after deatl To the Funerel Director: completely filled in by the	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the cause(s) and manner as stated. red at the time, date and place, and due to the cause(s)
	To the within 2 To the comple	ž	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
1			1 Standley all Jul D0185	2 DECOMBER 62004
		-	30 Name and address of person who completed cause of death (Item 23e) (Type, Print) Paul A. DEVORE MD 4203 QUEENSBURY Rd Hyatte	
			Vaul A. DEVOREMA 4203 QUEENSBURY Rd Hyatt	to: le MD 20731
	Sta Registra		31. Date filed (Month, Day, Year)  32. Registrar's Signature	

			1 - For State of Maryland /	Department of Health  Certificate of Deal		al Hygien		39324
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) ANNA F. E. D. MWOS		D	ate of Death Ionth Da	1 0004	3. Time of Death
	Examin	er	4a. Facility Name (If not institution, give street and number)  BON SPCOUR HOSPITO  5. Social Security Number  6. Sex  7. Age (In yrs., last be)	4b. City, Town, or Location  Baltimore  birthday) If Under 1 Year   If Under	re		County of Death	place (State or Foreign
	Funeral Director	ector	213-96-2793 1□ M 2♥F 84 Usual Residence of Decedent	Yrs. Months Days Hou	rs Min.	ate of Birth fonth, Day, Yeer, AR 23, 1.		ryland
Maryla	I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. I fleating that hard Mental Hygiene, them 21 is marked other then "naturel; or Items 23a or 28a-f show other traumatic event. Its Medical Examinar must be notified at		MO NIA Balt	wn or Location				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
		Funeral Director	10e. Street and Number  2601 ROSIVN AVE.  11. Marital Status  12. Was Decedent Ever in U.S.	10f. Zip Code  2/2/5	Origin? (Specify )	us	tizen of What Cou	
		þ	1 Never Married 2 Married If Yes, Give 1 Yes, Give Year or Dates:	13. Was Decedent of Hispanic If Yes, specify Cuban, Mexi		i, etc.)	Black, White,	
		Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	a. Decedent's Usual Occupation (Give kind of work done during n life. DO NOT use retired)	most of working	16b. K	(ind of Business/In	ndustry
		To Be Co	17, Father's Name (First, Middle, Last) ROLAND Edmunds		other's Name (Firs	t, Middle, Maider	Sumame) Thomas	S
			19a. Informant's Name/Relationship (Type, Print)  19 Vinnie Bûxter A	9b. Mailing Address (Street and Nu	mber or Rural Rou R. Bal	te Number, City	or Town, State, Zip	o Code)
Baltimore,	m 0		1	of Disposition (Namé of lery, crematory or other place)	12-15-	04 Du	ocation - City or To	own, State
Ba Ba	permit. Page Department of Important: If any injury of once.		21. Signature of Funeral Service Up 19509  23a. Party Enter the disease, or complications that caused the death. Do	22. Name and Address Fa	hF/Has	70 Fredi	hiltonPas	S Balto, Mo Approximate
Y.	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed XI within 24 hours after death.  Within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physician and XI may be completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		shock, or heart failure. List only one cause on each line.	TION PNE	Umoni	1		Interval Between Onset and Death
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	IAL INFARCTION  901):		V		ž
		ai Examiner	Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence	ə of):				
ox 687		n/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant				23d. Date of delive	өгу
l Records, P.O. B		ted by Physician/Me	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	9□ Unknown			Month Day Year	
			Part II. Other significant conditions contributing to death but not resulting	gg			d tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Onknown	
		Completed			1	4a. Was an autopsy performed?	death?	ppsy findings available impletion of cause of
		Certification; To Be						(y)
			1 Natural 5 □ Pending (Month, Bay Yeer) 2 □ Accident investigation	Time of njury 28c. Injury at Work?  M 28c. Injury at 28d. Describe how injury occurred 1				
			3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, building, etc. (Specify)	City or T		ity or Town, State		
		Medical	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one)  Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
			29b. Signature and title of certifier  I lance 7, Same	29c. License numb	2013	29d. Da	te signed (Month,	Day, Year)
	\		30. Name and address of person who completed cause of death (Item 23a	(Type, Print) Bon Slows	s Husp	ital, B	altimor	e md.
	Sta Registr		31. Date filed (Month, Day, Year)  DEC 1 3 2004  32. Registrar's Signature	& land				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Reg. No.- U U La Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** December 6, Lynn Marie Ely 2004 11:05 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Baltimore Towson If Under 1 Year | If Under 24 Hrs.
Months | Davs | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days 1 ☐ M 2 👿 F 48 214-66-6298 Director 11.1956 Maruland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Exerciner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8907 Mavis Avenue 21236 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 Married laryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Loan Document Processor Financial 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick F. Gloria Caples 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Gail Reaser 843 Julie Drive, New Freedom, PA item 27 l (sister) 17349 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 ō 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ö `4 □ Donation 5 □ Other (Specify) Bayview Crematory 12/10/2004 Baltimore, Maryland injury 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** breast cancer webs butic 40005 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Physician/Medical Examiner Cause (Disease or injury that initiated events resulting in death) Last burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 1 Yes 2 No Certification: To ther (Specify) HOSPICE 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending investigation 1 Natural after death. I Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and 29c. License number 58303 INN

Registrar
DHMH 17 Rev 1/2001

State

6601 N. Charles Street

Towson, Md. 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

m

32. Registrar's Signature

CHARLIES

AMON

31. Date filed (Month, Day, Year)

DEC 1 3 2004

			State State Registrar	e of Maryland / Depa <i>Cei</i>	artment of Health and I tificate of Death	Mental Hygie Reg.	
			Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year 3. Time of Death
	Physici /Medic		THELMA M. FRAZIER			Decemb	Der09.2004/0:00 AM
4	Examin		4a. Facility Name (If not institution, give street and	d number)	4b. City, Town, or Location of Deat		4c. County of Death
			CITIZENS CARE CENTER		HUVIEDE	sroce	Hortord
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)  F Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	(Month, Day, Ye	
	Director		423-34-1657	7.6		May 28, 1	928   ALABAMA
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation		10d. Inside City Limits
	f sho	ō		1000000	7		1 ☐ Yes 2X☐ No
	28a	Director	MD HARFORD  10e. Street and Number	ABERDEEN	10f. Zip Code	10g.	Citizen of What Country?
	3a or	Ö	80 MOYER DRIVE		21001	ti	.S.A.
	death with the Maryland ms 23a or 28a-f show Errust be notified at	Funerai	11 Marital Status 12. Was	Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puerl		14. Race - American Indian,
9	after or Ite		1 ☐ Never Married 2 ☐ Married 1 ☐ `	res 2 TNo	_	to rican, etc.)	Black, White, etc.
8	hours after tural', or Ite	d b	3 XWidowed 4 □ Divorced Year	or Dates:	1 ☐ Yes 2 🔀 No Specify:		Specify: BLACK
21215-0036	72 h	Completed	15. Decedent's Education (Specify only highest grade comple	ted) (Give	dent's Usual Occupation kind of work done during most of wo	rking 16t	b. Kind of Business/Industry
21	within ene. than "	du		ge (1-4or 5+)	DO NOT use retired)		TRUCA ETON
2	e filed within al Hygiene. I other than " vent, I'm Ma	ပိ	12 17. Father's Name (First, Middle, Last)	4   TEAC	CHER 18 Mother's Nat	me (First, Middle, Mai	EDUCATION  dec Sumame)
and	be fi	Be				2.	den Sumame,
Ĕ	2 should be and Mental is marked o	ဥ	R. C. MARINER  19a. Informant's Name/Relationship (Type, Print	10h Mailie	AUDREY  Address (Street and Number or Ri	MCSWAIN	ity or Town State Zin Code)
Maryland	d 2 st th and 7 ts r traur				OYER DRIVE ABERDE		
	ss 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene and Health and Mental Hygiene item 27 is marked other than "natural", or Items 23e or 28e-f show item 27 is marked other than "natural", or Items 12e notified at other traumatic event, I'm Medical Erac's and must be notified at		BARBARA WOODFOLK/SISTED  20a, Method of Disposition	20b. Place of Dispo	sition (Name of		c. Location - City or Town, State
ē	ages nt of t: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal 6  4 ☐ Donation 5 ☐ Other (Specify)	rom State	natory or other place)	14 2004 75	DEDDEEN MD
altimore,	permit. Pages Department of I Important: If ite any injury or o		21. Signate of Funeral Service Licensee	The second secon	MEM. CEMETERY 12-  Name and Address of Facility	14-2004 AE	SERDEEN, MD
Ba	permi Depa Impo any it		May bear (A		illiam C. Brown C 21 S. Philadelphi		
			23a. Part1. Enter the disease, or complications to shock, or heart failure. List only one cause				
	Photosopher .		Immediate Cause (Final	on each line.			Onset and Death
	Physician /Medical		disease or condition resulting in death)	e to (or as a consequence of):			12 A12
	Examiner						
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	e to (or as a consequence of):			
	cate be executed physician and the burial-transit	Examine	riany, leading to immediate cause. Enter Underlying Cause (Disasse or killury that initiated events c.				
0,	cate be execu ohysician and the burial-tra		resulting in death) Last Du	e to (or as a consequence of):			
8760	ate b hysic the bi	dicai	d		<del> </del>		
9	entific ling p	a)	IF FEMALE:				
Вох	eath certific attending p for use as	ian/	23b. Was decedent pregnant		Ectopic pregnancy		23d. Date of delivery  Month Day Year
_	the a	ysic		Pregnant at time of death 5  Jnknown	Other (specify)		
P.0	The law requires that the death certific te has been signed by the attending I age 2 should be detached for use as	by Physician/M	Part II. Other significant conditions contributing	to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
ds,	uires that signed t Id be det	d b	Delrydration	Dialoute	is relileis	1 ☐ Yes	2 No 3 Probably 4 Unknown
ò	w require been si should t	ete	. 0			24a. Was an	24b. Were autopsy findings available
Re	The law ate has page 2:	Completed				autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
Ta	, a <del>o</del>		25. Was case referred to medical		26 Place of De	1 Yes 2 2 ath (Check only one)	No 1 ☐ Yes 2 ☐ No
S	Physician: this certific ral director,	o Be	examiner?  1 Yes 2 No Hospital:	1 ☐ Inpatient 2 ☐ ER/Outpatier			e 6 Other (Specify)
10		12	27. Manner of Death 28a. I	Date of Injury (Month, Day Year)  28b. Time o		28d. Describe how i	
ion	Attending I r death. ector: After by the funer	atio	2 Accident investigation	monin, bay roary injury	M 1 ☐ Yes 2 ☐ No		
Division of Vital Records,	r Atte	tific	3 ☐ Suicide 6 ☐ Could not be determined 28e.	Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, State)
	ital or irs afte ral Dir led in	Certification:				ļ	
	Hospital	ical	(Check only 2 Medical Examiner: On	the basis of examination and/or in	n gcurred at the time, date and place vestigation, in my opinion, death occu	e, and due to the caus urred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	the the	Medical	one) and 29b. Signature and title of certifier	manner stated.	29c. License number	29d.	Date signed (Month, Day, Year)
	5 1 × 10		1 Wwar	MD	D32-609		12/9/04
,	\		30. Name and address of person who completed				1 1
	1		Kamruchy Milia		evalution St	Havre D	e (prace mo 2/078
	Sta	te		32. Registrar's Signature			
	Regist		DEC 1 3 2004	heneras p	1 hoored		

Frazier. Thelma

			1 - For State Registrar	State of Maryla	and / Depa	artme <i>rtifica</i>	nt of H	lealth and Death	Ment	al Hygie		104	39327	7
	Physicia	an	1. Decedent's Name (First, Middle, Last)							ate of Death Jonth	Day	Year,	3. Time of Death	
	/Medic	al	RUTH H. FLETCHER			4h Cih	. Town o	al costion of Dec	- 1	2- 6	18 -	v of Death	12:40 PM	_
	Examin	er	4a. Facility Name (If not institution, give s			0	. 1	r Location of Dea	L(I)			more	7	
*	Funeral Director		Frankly Square Hos 5. Social Security Number 6. Sex 213-14-9992		rs. last birthday) Yrs.		SEGA er 1 Year Days	If Under 24 Hr Hours Mir	۱. (۸	ate of Birth Month, Dey, Ye	ar)	9. Birthp	place (State or Foreign ntry) ryland	
_	and w		Usuaf Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	ocation				•			10d. Inside City Limits	_
	he Maryik 28a-f sho	Director	Maryland Baltimor		•	win		timore	Coun		Old 4		1 ☐ Yes 2 <b>X</b> O(No	
	with t	i Dir	15 Kincaid Court			101. 2	ip Code	21013		10g.	USA	What Cour	itry?	
	death	Funerai		2. Was Decedent Ever in	U.S. 13.	Was Dec	edent of H	lispanic Origin? ( an, Mexican, Pue	Specify \	es or No-		ce - Americ		-
9036	72 hours after death with the Maryland natural", or items 23a or 28a-f show lical Exacilitat natal be rediffed at	by	1 Never Married 2 Married  3XXWidowed 4 Divorced	Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:			aCTY Cuba	Specify:	rto Hican	ı, <i>e</i> (c.)	Specil	rck, White, fy: W	etc. hite	
215-0	within 72 hours ene. then "naturel", the Madical Exe	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12 YTS			kind of w DO NOT	ork done use retired	ation during most of widt)	orking	I	laryla he B		chool for	Ī
Fletcher, Auth Baltimore, Maryland 21215-0036	be filed tal Hygi d othar	To Be Cor	17. Father's Name (First, Middle, Last)  Carville Hersch	N/ A	360	reta	гу	18. Mother's Na			den Sumar			_
Fletcher,	nd 2 should lith and Men 27 is marker r traumatic	1	19a. Informant's Name/Relationship (Type Darryl G. Fletcher		1	_		and Number or F	Rural Rou	te Number, C	ity or Town		Code)	
letc.	ages 1 arent of Healert Healer		20a. Method of Disposition  X Burial 2 □ Cremation 3 □ Re  4 □ Donation 5 □ Other (Specify)	SINOVALINON STATE	Place of Dispo cemetery, cre-				Date 11~20	200 200 200 200		- City or To		_
alti i	mit. F partm portar y injur		21. Signal re of Funeral Service License				-	ss of Facility						-
Õ	Depa Impo any i		Catha reson	Characi.				ir Rd.					21236	
	Physician		23a. Part1. Enter the disease, or complice shock, or hear failure. List only on Immediate Cause (Final disease or condition	eations that caused the de e cause on each line.	ath. Do not en	ter the mo	ode of dyin	ig, such as cardia	ac or resp	piratory arrest,			Approximate Interval Between Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a cons		00.	1	0 1:1						_
6	Ŋ	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons	dicim d	1++1	cile (	Colitos	_					
die	tuted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Humkale	emig									
,0,	ie be executed ysician and e burial-transit	Exa	resulting in death) Last	Due of or as a cons	equence of):									
8760,	9 × 6	dicai	d	C-diffic	ile afte	rar	hbic	otics						_
P.O. Box 68	eath certific attending p	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3c. If yes, outcome of preg 1 Live birth 2 For a line of the control of the contr	etal death 3	⊒Ectopic ⊒ Other (s	pregnancy specify)	,				ate of delive	ery Day Year	
	that the de ed by the detached	Phy	Part II. Other significant conditions cont	tributing to death but not a	resulting in the u	inderlying	Called div	en in Part I		23e Did tobac	CO USA CON	tribute to th	ne cause of death?	
ords,	w requires tha been signed should be del										2 No		pably 4 ∐Unknown	
Division of Vital Records,	ysician: The law is certificate has b director, page 2 s	Completed					-			4a. Was an autopsy performed  Yes 2 12	13/	Were autoprior to condeath?	psy findings available mpletion of cause of	
Vita	sician: certific rector,	Be	25. Was case referred to medical examiner?	ospital:			Oth	26. Place of De	eath (Che	eck only one)				_
of	Physical direction	. To	1 Yes 2 No	1 Pinpatient 2	ER/Outpatier			4   Nuising		S Residence Describe how i			y)	_
sion	Attending I death. ctor: After y the funer	cation	1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year,	) In <del>j</del> ury	М	28c, Injun Wor 1 🔲	k? Yes 2 □No						
Divi	ital or Atirs after dial Direct	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - Al building, etc. (Spe	t home, farm, st ocify)	reet, facto	ery, office			ocation (Stree lity or Town, S		per or Rura	ti Route Number,	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edicai	29a. Certifier 1 ☑ Certifying Phys (Check only 2 ☐ Medicel Examin one)	icien: To the best of my ker: On the basis of examand manner stated.	nowledge, deat ination and/or in	vestigatio	n, in my o	pinion, death occ	e, and decurred at	ue to the caus the time, date	e(s) and ma and place,	anner as st and due to	ated. ) the cause(s)	
	To 1 To 1	Σ	29b. Signature and title of certifier				9c. Licens		- 3			-	Day, Year)	
	A		30. Name and address of person who con	mpleted cause of death (I	tem 23a) (Type.			265					500H	_
_	1		Dr. Jason M. Birnbai	im 9000 Fran	Klin Squ	uare	Drive	e Balti	mor	e, Ma	2/2	137		
	Sta Registr		31. Date filed (Month, Day, Year) DEC 1 3 200		nature	phy .	socie.							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Physician 12/11/2004 7:20 A<sup>M</sup> Geraldine Delores Fox /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 6 Ridge Road Glen Burnie Anne Arundel | Funder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 12/19/1927 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🗷 F Director 214-24-3096 76 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heelth and Mental Hygiene. Int: If item 27 is marked other then "naturel; or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State in then "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 MNo Director Glen Burnie MD Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21060 U.S.A. 6 Ridge Road Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates: Specify: White 3 Midowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) of Heelth and Mental Hygiene. Item 27 is marked other then 'r other treumetic event, Ir e Ma Elementary/Secondary (0-12) College (1-4or 5+) 8 Meat Wrapper Grocery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဂ္ John Otto Carl Olivia Foxwell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 109 Martha Road, Glen Burnie, MD 21060 Anita Anthony/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or ö \* 4 □ Donation 5 □ Other (Specify) Glen Haven Mem Pk 12/14/04 Glen Burnie, MD 21. Signature of Eugeral Service/Licensee 22. Name and Address of Facility G. J. Gonce Funeral Home, | 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of: Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760. Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month ò in the past 12 months? Year Day 5 Other (specify) signed by the aid be detached for 9 Unknown 9 Unknown Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No 2 No 1 TYAS funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: 4 Nursing Home Residence 6 Other (Specify) Certification: To this 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No efter death. 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide To the Hospitel within 24 hours To the Funerel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only 29b. Signature and title of certified 2 044804 30. Name and address of person who complete cause of death (Item 23a) (Type, Print)

Karin M Dodge MP 8028 Ritchie Huy sinte 134 Pasadena MD 21122 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar to Aporte

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. Ne. U Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1130 A AVID · Re FISHER 04 /Medical RANDAIS CAG Rounty of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Mar 7, Chapel Hill Nursing Center 4511 RobussonRdi Baltimore 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F 217-30-355 70 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State show 27 is marked other than "natural", or Itams 23a or 28a-1 sho: traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2X No MD Baltimore Randallstown Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4511 Robosson Road 21133 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should ba filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify Specify: white Completed by 3 ☐ Widowed 4 ☒ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) gunsmith 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last)

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Examiner

Completed by Physiclan/Medical

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Certification;

Medical

item 27 i

Department of h Important: If ite any injury or ot once.

Physician

/Medical

attending physician and for use as the burial-transit

signed by the a

peeu

certificate

this : After this funeral c

death. neral Director: /

within 24 hours a To the Funeral I

Examiner

To the Hospital or Attending Physician: Tha law requiras that the death cartificate be axecuted

Division of Vital Records, P.O. Box 68760,

with the Maryland

Baltimore, Maryland 21215-0036

Earl Fisher

Florence Brengle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19a. Informant's Name/Relationship (Type, Print) Karen Bernstein/daughter

7256 Lake Hills Court Marriottsville, MD 21104

20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 X Donation 5 ☐ Other (Specify) 21. Signature of Euneral Prvice Licensae ROD d S Waster

State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Immediate Cause (Final disease or condition resulting in death)

23a. Pant. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. noun Due to (or as a consequence of):

20b. Place of Disposition (Name of cametery, crematory or other place)

Approximate Interval Between Onset and Death

20c. Location - City or Town, State

unk

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

ocurren Due to (or as a consequence of):

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 9 Unknown

23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 4□Pregnant at time of death 9 Unknown

3 ☐ Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Other:

25. Was case referred to medical examiner? 1 Inpatient 2 ER/Outpatient 3 DOA

24a. Was an autopsy performe 2 4 1 TYes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

1 Yes 2 No

29b. Signature and title of certifier

27. Manner of Death 1 Matural 5 Pending investigation 28a. Date of Injury (Month, Day Year)

28c. Injury at Work? 28b. Time of

4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

2 Accident 6 ☐ Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Tes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

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12/02

State Registrar

Kawa lahoora 31. Date filed (Month, Day, Year)
DEC 1 3 2004

32. Registrar's Signature

20, Cross road

Amend Please Type or Print in Black Indelible Ink Finsure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 1 **Physician** /Medical 4b. City Town, or Location of Death 4a. Facility Name (If not institution, give st **Examiner** Bal HMORE lica If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 28-8342 Yrs **V**A Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, it e Medical Examiner must be notified at 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö or Items 23a Funeral 12. Was Decedent Ev Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White filed within 72 hours after thygiene.

Hygiene.

Ither than "natural", or Itel Never Married 2 Married Baltimore, Maryland 21215-0036 2 No 1 Tes Specify چ و 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Food Service Baltimore City Public 8th grade permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygie Important: If item 27 is marked other tany injury or other traumatic event, IL. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edwards Ethel James Edward Pearl Dixon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Friend 135 N. Bradford St., Baltimore, Md. 21224 Larry J. Crapper 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Suburial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-14-04 Mt. Zion Cem. Lansdowne, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 21202 Baltimore, Md. once ladip March F.H. East 1101 E. North Ave. 2ans 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) year Physician Cardiomyona /Medical Due to (or as a consequence of): Examiner CerebnVasul Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence or) Examiner Scheme burial-transit requires that the death certificate be executed 6 wilce Bons resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physicien Physician/Medical as the IF FEMALE nse 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy or in the past 12 months? Dav Year 5 Other (specify) ☐Yes 2☐No detached 9☐ Unknown 9 🗆 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ ed bluods Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA this completely filled in by the funeral 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred Certification: After (Month, Day 1 Natural 5 Pending M 1 ☐ Yes 2 ☐ No death. investigation To the Hospital or Attend within 24 hours after death To the Funeral Director: 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and title of cortifie 29c. License number Thow from, MD, FACP 51088 0 DECEMBER OF, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

301 St. PAUL PLACE, # FOI, BACTIMORE, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

**ORIGINAL** 

			1 - For State Registrar	State of M	larylan		artmen <i>tificat</i>			and M	ental Hy	giene Reg. No.	004	39331
	Physici		Decedent's Name (First, Middle, L.	ast)	MIA	6	WSK 1				2. Date of De Month	Day	Year 04	3. Time of Death 0926 4M
	/Medic Examin		4a. Facility Name (If not institution, ga			U	- 2/1	Town, or	Location o	of Death	16		ounty of Death	1 0,00
			JOHNS HOPKINS KAYVIE	W MED.	CTR.			BAZ	TIMOR					
	Funeral Director			Sex 7. A 1 □ M 2 ■ F	ge ( <i>In yr</i> s. <b>84</b>	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bir 07/25/	†920	9. Birthp Masss	lace (State or Foreign Chusetts
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	Od. Inside City Limits
	Maryl.	ō	Maryland N/A			timore								1 <b>X</b> Yes 2 ☐ No
	r 286	Directo	10e. Street and Number	1	Dar	CIMOLO	10f. Zip					10g. Citizer	of What Coun	try?
	th wit		620 S. Wolfe Stre	et			212	31				Unite	ed State	es
98	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If itam 271s marked othar than "natural", or Items 23e or 28e-f show or other traumatic event, the Medical Examinat must be notified at	y Funeral	11. Marital Status  1 Never Married 2 Married	12. Was Deceder Armed Forces 1 Tyes 2	No.	1	Was Deced f Yes, spec f □ Yes	ify Cubar	spanic Ori Mexican Specify:	gin? (Spe i, Puerto F	cify Yes or No Rican, etc.)		Race - Amend Black, White,	etc.
Ö	hours tural',	ed by	3 Widowed 4 □ Divorced	Year or Dates	:	16a. Deced	iont's Heur	I Occupa	tion				of Business/Inc	
15	in 72 n "nat	olete	15. Decedent's 1 (Specify only highest g	rade completed)		(Give	kind of wor DO NOT us	rk done di se retired)	uring mos	t of workin	ng	16b. Kind	or business/inc	lustry
212	od within gjene. ar than "	Completed	Elementary/Secondary (0-12)	College (1-4o	5+)	Homem	aker					DOmes	stic	
ng	be filed Ital Hygi Ital othar	Be C	17. Father's Name (First, Middle, Las	t)							(First, Middle		mame)	
yla	2 should be and Mental Is marked c	<sup>L</sup>	Unknown Rudzis								Unkno			
Maryland 21215-0036	12 sh h and 7 Is m traum		19a. Informant's Name/Relationship Dorothy Hayes- Da					,				-	own, State, Zip and 2122	
	1 and Health tam 27		20a. Method of Disposition	agricer	20b. F	Place of Dispo	sition (Nan	ne of	1		ate		ion - City or To	
100	ages ent of nt: If if		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec		B)	semetery, cren Stanis			· .	12/1	3/04	Balti	more, 1	Maryland
Baltimore,	permit. Pages Department of I Important: If it any injury or o'		21. Signature of Funeral Service Vol				. Name an	d Addres:	s of Facilit eber	Fune	ral Ho	mes P.	A. Mary	land 21231
	18 15 3		23a. Part1. Enter the diseas year conshock, or heart failure. List only	mplications that cause	ed the deat	h. Do not ent		-						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	,	SE	1515								Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	s a conseq	uence of):								o page
	LAdimines	<u>.</u>	Sequentially list conditions,	b. — Due to (or a	s a conseo	mence of/.							-	
	nted I Insit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	500 10 (01 0	3 4 0011300	1001100 01).							1	
Ć.	execu an and rial-tra		that initiated events resulting in death) Last	Due to (or a	s a conseq	uence of):								
8760,	ate be executed hysician and the burial-transit	dlcal		d									-	
9	death certificate be executed e attending physician and nd for use as the burial-transii	Med	IF FEMALE:	00-16										
Вох	death certific attending pl	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant	2 Feta	Ideath 3	Ectopic pr					23d	<ul> <li>Date of delive Month</li> </ul>	ry Day Year
o.		yslo	1 ☐ Yes 2 🗖 No 9 ☐ Unknown	9☐ Unknown	at time or c	eatii 3	J Other (sp	ecity/						
٣.	requires that the veen signed by th hould be detache	by Pl	Part II. Other significant conditions	contributing to death	but not res	ulting in the ur	nderlying c	ause give	n in Part I.		23e. Did t	tobacco use	contribute to th	e cause of death?
rds	v require been sig should b	ed t	STIMKE,	CHMWIC	VENTI	LATION	'		-		1 🗆	Yes 2 🗖 N	lo 3 Prob	ably 4 □Unknown
Records	aw as t	Completed									24a. Was	psy	prior to cor	osy findings available npletion of cause of
H		Con									perfo	2 No	death?	2 <b>∑</b> No
Vital	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe	pro.		(Check only o			
	Phys r this sral dii	To	1 Yes 2 No 27. Manner of Death	28a. Date of In	jury	ER/Outpatien		8c. Injury Work	4 🗀 140		ne 5 Resi		Other (Specify ccurred	")
on	Attanding Phy r death. actor: After this by the funeral d	atlor	1 Natural 5 Pending 2 Accident investigati	(Month, D	ay Year)	Injury	М		? ′es 2 🔲	No				
Division of	of or Attand after death Diractor: /	Certification:	3 ☐ Suicide 6 ☐ Could not determine	286. Place of I	njury - At h	ome, farm, str	eet, factory	, office		2	8f. Location (		lumber or Rura	Route Number,
	rs after or ral Dir			Dallowing,	sto. (Opoon									
	To the Hospitel or Attentwithin 24 hours after deatl To the Funaral Director: completely filled in by the	ledical		hysician: To the besiminer: On the basis and manner:	of examina		estigation,	in my op	inion, dea			date and pla	ace, and due to	the cause(s)
	To tha h within 24 To the I	Σ	29b. Signature and title of certifier	//			290	. License				29d. Date s	igned (Month, I	Day, Year)
	10		· /w/ /	h MO				RES	-000			12	9104	
	U		30. Name and address of person who	completed cause of	death (Iter <b>444/)</b>	n 23a) (Type, EASTEAN		e	Kan	nalus	2 M	1) 7.12	224	
	Sta	te	31. Date filed (Month, Day, Year)		trar's Signa	ature				U WYOU	/ / /	, ,,,,		
	Registr	ar	DEC 1 3	2004	Eggen	e g		1						

DHMH 17 Rev 1/2001

ORIGINAL

			1 _ State	partment of Health and Menta ertificate of Death		ne 2004	30222
			Registrar  1. Decedent's Name (First, Middle, Last)	2. Dat	te of Death		3. Time of Death
	Physicia /Medic			<del></del>		5, 2004°	6:00 PM M
	Examin	er	4a. Facility Name (If not institution, give street and number) Somerford Assisted Living	4b. City, Town, or Location of Death Frederick	4	4c. County of Death Frederic	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	v) If Under 1 Year   If Under 24 Hrs.   8 Dat	te of Birth	9 Birth	place (State or Foreign
	Director		577-20-5762 1□ M 2X F 91 Yrs.  Usual Residence of Decedent	Dec	onth, Day, Yea	1912 Nort	h Carolina
	yland how		10a. State 10b. County 10c. City, Town or				10d. Inside City Limits
	8a-fs	ector	Maryland Frederick Jeffers				1 ☐ Yes 2 ♣ No
	72 hours after death with the Maryland naturel', or Items 23a or 28a-f show disal Examili without ke notified at	Funeral Director	4531 Timbery Drive	10f. Zip Code 21 <b>7</b> 55		Citizen of What Could S.A.	ntry?
	ems 2	inera	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	B. Was Decedent of Hispanic Drigin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican,	es or No-	14. Race - Ameri Black, White,	
36	It, or It	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 1 Year or Dates:	1 ☐ Yes 🍇 No Specify:		Specify: Whi	
2-00	72 hounature		15. Decedent's Education 16a. Dec	edent's Usual Occupation we kind of work done during most of working	16b.	Kind of Business/In	ndustry
121	within ene.	Completed	Flementary/Secondary (0-12) College (1-4or 5+)	. DO NOT use retired) stered Nurse		Health Ca	re
Maryland 21215-0036	filed Hygi other	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name (First,	Middle, Maid		
ylar	should be ind Menta i marked umatic ev	To E	John Durant Bell	Ella Sway			
Mar	s 1 and 2 should f Health and Men item 27 Is marke other treumatic			iling Address (Street and Number or Rural Route 1 Timbery Drive, Jeffe			o Code)
ore,	es 1 ar of Hea f item ?		20a Method of Disposition 20b. Place of Disp	rematory or other place)		Location - City or To	
Baltimore,	permit. Pages Department of i Importent: If it any injury or o		`4 □Donation 5 □Other (Specify) Smlthsbir	g Crematory Dec. 7, 2	2004 S	mithsburg	s, MD
Bal	permii Depar Impor any ir once.		21. Signature of Funeral Service Licensee  MO0255	22. Name and Address of Facility Keeney and Basford PA 106 Fast Church St.,	\ Funer Freder	al Home	21701
г			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or respin	ratory arrest,	,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	cardial inforc	Han		1 Day
Н	Examiner						/
	led sit	niner	Sequential vilst conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
., .,	be executed ician and burial-transit	Examin	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
8760,	cate be executed chysician and the burial-transit	edicai	d				
Box 6	The law requires that the death certificate to has been signed by the attending physoage 2 should be detached for use as the	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delive	ery
	s death he atte	Physician/M	in the past 12 months?  1 Yes 2 No  1 Ulakanya	B □Ectopic pregnancy Di □ Other (specify)		Month	Day Year
P.0	that the de ted by the a		9 Unknown  Part II. Dther significent conditions contributing to death but not resulting in the	underlying cause given in Part I. 23	Be. Did tobacc	o use contribute to t	he cause of death?
rds,	w requires been sign should be	ed by	Hyportension		1 🗆 Yes	2 No 3 □ Prot	oably 4 Unknown
of Vital Records,	e law re has bee	Completed	J'	24	la. Was an autopsy	prior to co	ppsy findings available impletion of cause of
alB					performed	death? No 1 ☐ Yes	2□ No -
/ Vit	Sicie	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpati	26. Place of Death (Check ient 3□ DOA Dther: 4□ Nursing Home 5		6 XOther (Special	Assisted
0		on: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending (Month, Day Year) 28b. Time (Month, Day Year)	/ Work?	escribe how in	jury occurred	Faulity
Division	ten leat tor: the	licati	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury. At home, farm, s	M 1 ☐ Yes 2 ☐ No  street, factory, office 28f, Loc	cation (Street	and Number or Rura	al Route Number,
Ω	s after s after el Dire	Certification:	4 Homicide determined building, etc. (Specify)	Cit	ty or Town, Sta	ite)	
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical	29a. Certifier  (Check only one)  Certifying Physicien: To the best of my knowledge, dei and manner stated.				
	To the within 2 To the complet	Med	· /	29c. License number	29d. [	Date signed (Month,	Day, Year)
)			shan Hiren, mi	D51643	De	ecember 6,	, 2004
	12		30. Name and address of person who completed cause of death (Item 23a) (Type	e. Print) Dy Fredericks	mD	2171/2	
	Sta	te	31. Date filed (Month, Day, Year)  DEC 1 3 2004  32. Registrar's Signature	las di		V	
	Registr	ar	DECT 2 COOR	apours/			

07592	-	for Stata Registrar	State of M	aryland				lealth a Death		_	giene Reg. No.	001	+	39333
Physicia	á.	1. Decedent's Name (First, Middle, La Nancy Geyer	ast)							2. Date of De Month Novembe	ath Day		ear	3. Time of Death  11:25 P.M
/Medica		4a. Facility Name (If not institution, given	ve street and number)			4b. City,	Town, or	Location				County of [		11.23 1.
Zamin	"	1 Smeton Place,	Apt 402			Tow	son				Bâ	ltimo	ore	County
Funeral		Social Security Number     6.3	Sex 7. Ag	ge (In yrs. la	ast birthday)	If Under	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th			ace (State or Foreign
Director	,	327-40-0401	1□M 2XF	75	Yrs.	IVIGITATIO		110010		July 31	<b>',</b> 19	29 M	ary	l'and
and		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation							10	d. Inside City Limits
//anyli	ō	MD Baltin	nore			wson								1 ☐ Yes 2X No
the f	rect	10e, Street and Number		1		10f. Zip	Code				10a, Citiz	en of Wha	t Count	v?
with 3a or	<u></u>	1 Smeton Place #	402					1286				USA		,,.
death ms 2	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S	5. 13.	Was Dece			gin? (Spe	cify Yes or No Rican, etc.)	- 1	4. Race - A	America	
or Ite	Ē	1 Never Married 2 Married	Armed Forces  1 Yes 2 A  If Yes, Give	No.	}			n, mexicar Specify:		rican, etc.)		Black, V		<sup>tc.</sup> 1ite
ours	d b	3 Widowed 4 Divorced	Year or Dates:				2451110	эрвспу.				Specify:	WI	iice
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. Hygiene, ther than "natural", or Items 23a or 28a-f show ont, the Medical Exacult without at	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Dece	kind of wo	al Occupa	ation <i>during m</i> os ()	t of workir	1g	16b. Kin	d of Busin	ess/indu	ıstry
withir than	ш	Elementary/Secondary (0-12)	College (1-4or	5+)		ning					U.S.	Pead	ce C	orps
d 212 filed with Hygiene. wher than		17. Father's Name (First, Middle, Las							er's Name	(First, Middle,	L			
Maryland d 2 should be file th and Mental Hy ty Is marked oth traumatic event	To Be	John Clinton Bro	otemarkle					Cora	a Ali	ce Eid	e1			
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Marylan Hygiene. Health and Mantal Hygiene. stem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinations to filling an		19a. Informant's Name/Relationship  Jane Brown/life								Route Number	_	Town, Sta		Code)
ore, M		20a. Method of Disposition		20b. PI	ace of Dispo					ate		ation - City		n, State
imor Pages nent of 1 ant: If its		1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 🛣 Donation 5 ☐ Other (Speci			metery, ore	natory or c	niiei piac	•/						
Baltimore, permit. Pages 1 a Department of Hea Important: If item any injury or othe		21. Signature of Euneral Service Lice Ronal of S.	ir all ir	ector	Si Ba	Name ar tate 11tim	Anato	ss of Facilit Omy B MD	oard 21201	655 W.	Ba1	timor	e St	treet
76		23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that cause	d the death	. Do not ent	er the mod	le of dyin	g, such as	cardiac o	r respiratory a	rrest,			Approximate Interval Between
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Mixed Due to (or as	Drug a consequ	(AMi	tript	yline	Sert	ralini n	e) and	ALCO	hal		Onset and Death
Examiner	er	Sequentially fict conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	ence of):									
8760, cate be executed physician and the burial-transit	Examiner	that initiated events	C											
O, e exectan an an an an an an an an an an an an a		resulting in death) Last	Due to (or as	a consequ	ence of):									
8760, cate be exphysician the burial	Physician/Medical		_ d											
c 68	Med	IF FEMALE:											-	
Box 68 leath certifice attending pt	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Fetal	death 3[	Ectopic p					2:	3d. Date of Month		/ Day Year
that the de detached is	ysic	1 Yes 2 No	4□Pregnant a 9□ Unknown	t time or de	ain si	Other (sp	оеспу) <sub></sub>							
IS, P.		Part II. Other significant conditions	contributing to death t	out not resu	lting in the u	nderlying o	ause give	en in Part I.		23e. Did t	obacco us	e contribut	te to the	cause of death?
I Records, P.O. Box 68760, The law requires that the death certificate be executed at the has been signed by the attending physician and bage 2 should be detached for use as the burral-transit	d by	Atherosclerotic	Cardiova	scula	NDi:	sease				1 🗆 🕆	res 2 🗹	No 3[	] Probai	biy 4 🔲 Unknown
cord w requii	lete									24a. Was	an	24b. Were	autops	sy findings available
Vital Rec	Completed				·					autor perfo	rmed? 2 \( \text{No} \)	prior deati 1 🔼 `	to com	pletion of cause of
	0	25. Was case referred to medical						26. Place	of Death	(Check only o		A	165 2	140
of Vita Physician: this certificanal director,	6 B	examiner? 1∑Yes 2☐ No	Hospital: 1 Inpati	ent 2 🗆 E	ER/Outpatier	nt 3 🗆 DC	Othe	er: 4 □ Nu	rsing Hom	ne 5 ☐ Resid	dence 6	☐Other (5	Specify)	At scene
on of Vita ding Physician:  After this certific funeral director,		27. Manner of Death  1 Natural 5 Pending	28a. Date of Inju	ıry ıy Year)	28b. Time o	2	28c. Injury Work	rat c?	2	8d. Describe I	now injury	occurred	5 ub	iect.
Vision Attending r death. ector: After	atlo	2 ☐ Accident investigation	on 11-25-6		11:15	РМ	1 🗆 ,	Yes 2 💢	_			4		ulcohol
Division  or Attending after death. Director: After in by the fune	Certification	3 Suicide 6 ☐ Could not I 4 ☐ Homicide determined	building, e	tc. (Specify	me, farm, str	eet, factor	y, office		2	8f. Location (S City or Tox	Street and vn, State)	Number of	Rural	Place #40
ospital of hours at uneral D			Kesid		,						10W.	son,	MI	)
Hosp 24 ho Fune stely f	edical		hysician: To the best miner: On the basis of and manner st	of examinati										
DIVI To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Med	29b. Signature and title of certifier	and mainer st			290	c. License	number			29d. Date	signed (M	onth, D	ay, Year)
F 3 F ŏ		Carro L	900000	M.	d		OC	CME			Nover	nber :	26,	2004
	1	30. Name and address of person who	completed cause of	death (Item	2βa) (Type.	Print)					,			
		30. Name and address of person who	MAN	nie	1	111	Penr	n Str	eet,	Baltim	ore,	Mary.	land	1 21201
Stat Registra		31. Date filed (Month, Day, Year) DEC 1 3 2004	32. Registi	rar's Signat	1	park	1							

			1 - State Registrar  Ce	artment of Health and Me ertificate of Death	Reg	ene .No2004 39334
	Physici /Medio		1. Decedent's Name ( <i>First, Middle, L</i> ast)  JAMES ANTHONY GELTRUDE		2. Date of Death Month DECEMBE	Day Year R 9 2004 13.51 M
7	Examir		4a. Facility Name (If not institution, give street and number)  Good Samarrtan Hospital	4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE CITY
	Funeral Director		5. Social Security Number  169-24-8240  6. Sex 7. Age (In yrs. last birthday, 74 yrs.	) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day Y JULY II	9. Birthplace (State or Foreign Country) 1930 Crabtree, PA.
	Maryland f show led at	lor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L  MarylandBaltimore Balti	ocation .more County		10d. Inside City Limits 1 □ Yes 2 No
	h with the	al Direc	100. Street and Number 1815 Ellinwood Rd.	10f. Zip Code 21237	10g	. Citizen of What Country?
9003	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "neturel", or Itams 23a or 28a-f show important: If Itam 27 is marked other than "neturel", or Itams 23a or 28a-f show important; If Itam 27 is marked or 200. Itam 200.00 is notified at 200.00.	ed by Funeral Director	1 Never Married 2 Married If Yes, Give Year or Dates: 1954-1957	Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto R  1 ☐ Yes 2 Z No Specify:		14. Race - American Indian, Black, White, etc.  Specify: White
Baltimore, Maryland 21215-0036	filed within 72 Hygiene. other then "net ant, the Medici	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	odent's Usual Occupation e kind of work done during most of working DO NOT use retired) Veigh Worker	g	b. Kind of Business/Industry
/land	2 should be filed and Mental Hyg is markad otha aumatic evant,	To Be C	17. Father's Name (First, Middle, Last) Leo Geltrude	18. Mother's Name Clara McC		
, Mar	tand 2 sho Health and I tam 27 is me		James Horton (Stepson) 602	ing Address (Street and Number or Rural O Edlen Court Bryan	ntown, Mo	d. 20617
timore	permit. Pages 1 Department of H Important: If Ital any injury or ott once.	ıj	4 Donation 5 Other (Specify)	rematory ,Inc. 12~10-	-2004 Ba	c. Location - City or Town, State altimore, Maryland
Bai	permit Depar Impor any in		> E. J. Lassahn	7401 Belair Rd. Bal	ltimore,	
	Pnysician /Medical Examiner	9 5	23a. Part1. Enter the disease, of complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. CAFDIO RESPIRATO Due to (or as a consequence of):		respiratory arrest	Approximate Interval Between Onset and Death
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and sage 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. NEUMONIA  Due to (or as a consequence of):  c. LE EFFUS  Due to (or as a consequence of):  d. INTRA ABDOMINA			
P.O. Box 6	that the death certific ed by the attending p detached for use as	Physiclan/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
	w requires that been signed b should be deta		Part II. Other significant conditions contributing to death but not resulting in the POLYCYTHEMIA VERA	underlying cause given in Part I.		cco use contribute to the cause of death? 2 No 3 Probably 4 Unknown
II Reco		Completed by	SPLENECTOMY		24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? 1
f Vita	vysician: Th	To Be (	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Impatient 2 ER/Outpatie	26. Place of Death on 3 DOA Other: 4 Nursing Hom		e 6 ☐ Other (Specify)
Division of Vital Records,	or Attanding Physician: after death. Diractor: After this certifica in by the funeral director. I	Certification:	27. Manner of Death  1	of 28c. Injury at 28 Work?  M 1 Tyes 2 No	8d. Describe how	injury occurred at and Number or Rural Route Number,
D	To the Hospital or Attanc within 24 hours after death To the Funaral Diractor; completely filled in by the	al Cert	29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place, ar	nd due to the caus	se(s) and manner as stated.
	To the Hospital within 24 hours To the Funaral completely filled	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or in and manner stated.  29b. Signature and title of certifier	nvestigation, in my opinion, death occurred		and place, and due to the cause(s)  Date signed (Month, Day, Year)
	₹ <u>₹ ₹ 8</u>		Vygay Lepi MA	RES 000		ECEMBER 9,2004
	124		30. Name and a fress of person who completed cause of death (Item 23a) (Type VIJAY LAPSIA 5601, LOCH RAVE.		MORE , 1	MD 21239
	Sta Registi	_	31. Date filed (Month, Day, Year)  DFC 1 3 2004  32. Registrar's Signature	books		

DHMH 17 Rev 1/2001

Ger Honde

State of Maryland / Department of Health and Mental Hygiene 2004 39335 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 23:30 M **Physician** VERNON ROBERT HERTSCH DECEMBER 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** NA UNIVERSITY OF MARYLAND MEDICAL CENTER BALTMORE If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year 05/20/1951 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 1**M**M 2□ F Months Days Vrs Maryland 219-58-1950 53 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h Count 77 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Medical Examinar mastics for notified at 1 ☐ Yes 2 No Baltimore Woodlawn Maryland Direct 10g Citizen of What Country? 10e. Street and Number 10f. Zip Code 21207 United States 2021 Englewood Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 21215-0036 1 ☐ Yes 2 No Specify: Specify: δ White 3 ☐ Widowed 4 ■ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) State Government Carpentry 18. Mother's Name (First, Middle, Maiden Sumame) Maryland 17. Father's Name (First, Middle, Last) Be 2 should be finance and Mental H s 1 and 2 should b of Health and Ments item 27 Is marked Vernon R. Hertsch Sr. Ruby Belle Gorman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2021 Englewood Avenue Woodlawn, Maryland 21207 Ruby Hertsch - Mother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ott 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematiory 12/08/2004 Baltimore, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Day id J. W. ber Funeral Homes P.A.
15311 Edmondson Avenue Baltimore, MD 21229 21. Signature of Funeral Service Licens 23a. Part 1. Enter the disease, or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DAYS Physician HEMORRHAGE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 5 DAYS SHOCK SEPTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last One to (or as a consequence of): Examiner inding physicien and use as the burial-transit death certificate be executed 5 YEARS END STAGE LIVER DISEASE Due to (or as a consequence of): Box 68760. 16 YEARS HEPITITIS C Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ed by the a detached f P.O. 9 Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown ALCOHOL ABUSE Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an INTYZA-VENOUS DRUG ABUSE autopsy 2 No 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To this 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Hospital or Attending 5 Pending investigation Division 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical within 24 hor To the Fune completely fi (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number - M. Dans mo DECEMBER 8 2004 Kathlin 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
KATHLEN MIDAVIS MD UNIVERSITY OF MARYLAND MEDICAL CENTER
225. GREENE STREET BALTMORE, MO 21206 31. Date filed (Month, Day, Year) 32 Registrar's Signature State DEC 1 3 2004 oak Registrar

Physici	an	State State Unpend Item 23a, pt Registrar  1. Decedent's Name (First, Middle, Last)			1	2. Date of Death Month Da	y Year	3 9 3 3 3. Time of Death
/Medic	al .	Daniel Haney  4a. Facility Name (If not institution, give street and	number)	4b. City, Town, o	or Location of Death	ECEMBER 7	2004 County of Death	12:57p
Exami	eı	JOHN HOPKINS HOSPITAL	,		MORE CITY			
Funeral Director	1 1	5. Social Security Number 6. Sex 1 ★ M 2 □ I	7. Age (In yrs. last birth	Months Days	Hours Min.	3. Date of Birth (Month, Day, Year, 17/31/1953	9. Birth Cou Mary	place (State or Forei Intry) land
MC TI		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limi
or 28a-f show	tor	Maryland N/A	Baltimo	re City				1 Yes 2 ☐ N
	Funeral Director	10e. Street and Number		10f. Zip Code			tizen of What Cou	
18 23a	erai	117 South Robinson Stre	et Decedent Ever in U.S.	21224	Hispania Origin? (Spec		ted State	
Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a and righty or other treumatic event, the Mudical Examiner man and rights.	by Fune	1 Never Married 2 Married 1 Yes.	Forces?	If Yes, specify Cub	Hispanic Origin? (Spec an, Mexican, Puerto Ri Specify:	can, etc.)	Black, White	
natura Ical E	ted	15. Decedent's Education	16a. D	Decedent's Usual Occup	pation	16b. K	ind of Business/Ir	
Man "n	Completed		e (1-40r 5+)		during most of working d)	1		
dygier ther th	Cor	12 17. Father's Name (First, Middle, Last)	ETec	ctrician	18 Mother's Name /	Ele First, Middle, Maider	ctrical	Repairs
Mental F arked of atic ever	To Be	Unknown			Unknown			
hand 7 is m treum		19a. Informant's Name/Relationship (Type, Print) Linda S. Haney– Wife			and Number or Rural			,
Healt tem 2 other		20a. Method of Disposition	20b. Place of D	Disposition (Name of	Da		ocation - City or T	
ent of nt: If it ry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	om State Bayvier	crematory or other pla v Crematory		/2004 Bal	timore, 1	Maryland
Departm Importer any inju		21. Signature of Funeral Service Licensee	4 CFSP	22 Name and Address David J.	Weber Fune Wester Stre	ral Homes	P.A.	
90		23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of	at caused the death. Do no				orc, rar	Approximate Interval Between
ysician		Immediate Cause (Final disease or condition	otic Intoxic				4	Onset and Death
Medical aminer		resulting in death)	to (or as a consequence of	):				
ų.	ē	Sequentially list conditions, Due cause. Enter Underlying	to (or as a consequence of	r				
nd ransit	Examiner	that initiated events						
lysician and he burial-transit	cai	resulting in death) Last Due	to (or as a consequence of	):				
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the attend ched for us	Completed by Physician/Med	in the past 12 months?	outcome of pregnancy re birth 2 Fetal death egnant at time of death aknown	3 ☐Ectopic pregnanc 5 ☐ Other (specify) _	<b>y</b>		23d. Date of deliv Month	ery Day Year
ned by e deta	y Ph	Part II. Other significant conditions contributing t	o death but not resulting in t	he underlying cause gr	ven in Part I.	23e. Did tobacco	use contribute to t	he cause of death?
en sig ould b	ed	Liver Cirrhosis,Hepatit	is C			1 ☐ Yes 2	□ No 3 □ Prol	bably 4 Unkno
ite has be	omplet					24a. Was an autopsy performed?	prior to co death?	opsy findings availal empletion of cause of
ertifica ector. p	Bec	25. Was case referred to medical examiner?			26. Place of Death /			
this caldire	P.	XXYes 2 No	☐ Inpatient 2页 ER/Outp	atient 3 DOA		5 Residence		
After funer	tion	1 Natural 5 Pending Four	forth, Day Year) Found	dr. M No	rk?  Yes 2. <b>X</b> No	d. Describe how inju	ту оссиней ЦП	K
E . 0	ifica	3 Suicide 6 X Could not be 28e, F	ace of Injury - At home, farn	<b>p</b> n, street, factory, office		f. Location (Street ar City or Town, State	d Number or Rura	Al Route Number,
r death ector: / by the f	Certification:	4   nonlicide   Di	ulding, etc. (Specify) und at homele			1timore, 1		Centrar
s after des al Directo ad in by th		29a. Certifier (Check only one)  1 Certifying Physician: To 27 Medicel Examiner: On the and n	the best of my knowledge, e basis of examination and/ nanner stated.	death occurred at the troor investigation, in my	me, date and place, an opinion, death occurred	d due to the cause(s at the time, date and	and manner as s d place, and due to	tated. o the cause(s)
n 24 hours after der Funerel Directo fetely filled in by th	ğ	005 00- 1 4 50- 1 - 400-		29c. Licens			te signed (Month,	
within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as th	Medical	29b. Signature and title of certifier  Zu Luwwall	a Alex		OCME	DECEN	1BER 8, 2	2004
within 24 hours after der To the Funerel Directo completely filled in by th	Medi	30. Name and address of person who completed of CAB IUCA by	ause of death (Item 23a) (T	ype, Print) PENN STRE	OCME ET, BALTIM			

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician Рм Dorothy Helen Haines 2004 December 10. 7:40 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 1508 Old Eastern Avenue Apt B. Baltimore Essex If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

June 16, 1927 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F Yrs 213 18 7497 Director Maryland Usual Residence of Decedent Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f shov treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Directo Maryland Baltimore Essex the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with ö 21221 1508 Old Eastern Avenue Apt B. USA or items 23a Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify: White Completed by 3 Widowed 4 Divorced "neturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Menial Hygiene. Importent: If item 27 is marked other then "ne eny injury or other treumatic event, the Medic once. Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Seafood 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bertha Rumpf Christan Hedrich 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1508 Old Eastern Avenue Apt A. Baltimore, Md. 21221 Robert C. Haines (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens Of Faith Cemetery 12/14/2004 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cylock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASCULAR Pnysician ATHEROSCIEROTIC! /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons - uence of) Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760, attending physician by Physician/Medical the IF FEMALE esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year ģ in the past 12 months? 1 ☐ Yes 2 🖾 No 5 Other (specify) 4☐Pregnant at time of death P.0. detached 9 Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 2 X No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5X Residence 6 Other (Specify) P 1 ☐ Yes 2X No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death 2 🗌 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide within 24 hours a To the Funerel L 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

\*\*The description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Dec 13, 2004 35410 BATIMILE, MD 21237 30. Name and addless of person completed cause of death (Item 23a) (Type, Print) FFER IYA mo FE 6 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 3 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 1 tem#22, perFh G838, 12/13/04 TT State of Maryland? Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death North Day (, 2004) **Physician** Harris 300 Nellie R. /Medical 4c. County of Deeth 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/AJakyland Greneral MORE Year If Under 24 Hrs. 8. Date of Birth (Month, Day, May 22, 9. Birthplece (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) If Under 1 5. Social Security Number Year) 1919 **Funeral** 1 □ M 2 2 F 85 220-07-5102 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Pages 1 and 2 should be filed within 72 nows.
Iment of Health and Mental Hygione intent. Or frems 23a or 28a-f show tent: If item 27 is marked other then "naturet," or frems 23a or 28a-f show tent: If item 27 is marked other then "naturet," or frems 23a or 28a-f show tent it it is medical Expirit at intent be notified at Baltimore 1√Yes 2 No N/AMaryland Director 10e. Street and Number 10g, Citizen of What Country? 10f. Zio Code **USA** 1311 Carey Street 21217 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ♣☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Specify Black 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 🕱 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Clerk Years **Maryland** 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Carrie Spencer Harry B. Robinson 19b. Mailing Address (Street and Number of Rural Route Number. City of Town. State Zin Code) and 3811 Cedarhurst Road Baltimore, Maryland 21206 19a. Informant's Name/Relationship (Type, Print) Yvonne Hayward Baltimore, 20b. Place of Disposition (Name of 12/10/04 Park 20c. Location - City or Town, Stete 20a. Method of Disposition cemetery, crematory or other place) Arbutus Memorial permit. Pages 1
Department of H
Important: If its
eny injury or ot
once. Arbutus, Maryland 1 Surial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facil@hatman-Harris Funeral Home 21. Signature of Funeral Service Licensee Md 21216 5240 Reisterstown Rd Baltimore, Rish Approximate
Interval Between
Onset and Death 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final neumonia Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-transil and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physicien Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year in the past 12 months? detached for 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown signed by ( 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part J. 1 Yes 2 No 3 Probably peeu 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has certificate 1 ☐ Yes 2 No director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this funeral 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After t Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) yd ni bellif 4 - Homicide the Hospitel rocicertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title certifier 29c. License number 0 reserver, M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) eneral Hospi Mille razeka 32. Registrar's Signature State Registrar

**ORIGINAL** 

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Year **Physician** Maria Hemmer 12 01 04 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical Cer mnapolis If Under 24 Hrs. 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, **Funeral** Year) Days 1 M 2 D Director 101 Usuel Residence of Decedent Pegas 1 and 2 should be filed within 72 hours after deeth with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Millersville Anne Anuna 1X Yes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? or frems 23a or aminer must be r 21108 Be Completed by Funeral Wes Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates: 1□ Yes 2 No 3altimore, Maryland 21215-0020 Specify Specify: 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) none none none none Depertment of Heelth and Mentel Hygin Important: If Item 27 is marked other any injury or other traumatic event 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) temme? 2 udita Hemmen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 738 Cniciby Judita Hemmen/mother Millersville, MD 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 NOther (Specify) in state 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 Part1. Enter the disease, or comshook, or heart failure. List only lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Physician/Medical Examiner or Attending Physician: The law requires that the deeth certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the e completaly filled in by tha funeral director, pega 2 should be detached it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Medical Certification: To Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? †∐ Yes 1 🗆 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2☐ ER/Outpatient 3☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 No 28e. Date of Injury (Month, Dey 28c. Injury at Work? 27. Manner of Death 28h. Time of 28d. Describe how injury occurred 1 Naturel 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as stated 2 Indedical Examiner: On the basis of examination and/or investigation in my opinion, death 29a. Certifier Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 00 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) Suite 210 2003 Medica John P. McDonoug 31. Date filed (Month, Day, Year)

State

Registrar

PEG-1 3

32, Registrer's Signature

			For State	State	of Marylan			of Health				2001	+ 39	340
			Registrar  1. Decedent's Name (First, Middle	Lacti		00,	incate	Or Death	-	2. Date of Deat	bg. No. h		3. Time of	
	Physicia	an	Lla ON 12 L	Last/	LV.	00				Month Novembe	Day	Yeer		
	/Medic	_	4a. Facility Name (If not institution,	cive street and n	umber)	12	4h City To	own, or Location	of Death	Novemb		ounty of Dea		Ari
	Examin	er	Vantage House	give street and n	united )			lumbia				Howar	d	
	Euparal		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1	Year If Unde	er 24 Hrs.	8. Date of Birth	V= ==)		thplace (State of	r Forei <b>g</b> n
	Funeral Director		577-60-5024	1 □ M 2 💢 F	99		Months	Days Hours	Min.	Nov 18,	190.	5 Was	hington	DC
	D		Usual Residence of Decedent											
	how		10a. State 10b. County MD Howa	1	10c. Cit	y, Town or Lo							10d. Inside Cit	
	Pa-f	cto	MD Howa	ra		Co1um	bla						1 🗆 Yes	2/11/10
	death with the Maryland	Funeral Director	10e. Street and Number				10f. Zip C			1	0g. Citize	in of What Co	ountry?	
	23a	ral	5400 Vantage Po					2104				USA		
	de r	ne	11. Marital Status	Armed I		.S. 13.	Was Decede If Yes, specif	ent of Hispanic C fy Cuban, Mexic	origin? (Sp an, Puerto	ecify Yes or No- Rican, etc.)	14	. Race - Ame Black, Whit		
20	or l	by Fi	1 ZNever Married 2 Marri 3 Widowed 4 Divorced	If Yes, C	2 XNo		1 🗆 Yes 2]	No Specif	y:		S	pecify:	white	
3-003c	hour:			Year or	Dates:	16a Doce	dent's Usual	Occupation			16h Kind	l of Business		1
<u>.</u>	"nat	Completed	15. Decedent (Specify only highes	t grade completed	1)	(Give	kind of work DO NOT use	done during me	ost of work	ing	TOD. KING	01 00311033	industry	unk
7	within Bne. than	m d m	Elementary/Secondary (0-12)	College	(1-4or 5+) 5+			tician						
0	filed within 72 hours after Hygiene. Ither than "natural", or Ite ont, the Mayleal Examina	ပိ	17. Father's Name (First, Middle, I	_ast)					her's Nam	e (First, Middle, I	Maiden St	umame)		
/land	d be ental	00	Milton James H						Nor	ma Lewis				
	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan rathrans of Health and Mental Hygiene. ortant: If time 27 is marked other than "natural; or teams 23a or 28a-f show injury or other traumatic event, the Moulcul Examinar must be notified at injury or other traumatic event, the Moulcul Examinar must be notified at 8.8.	2	19a, Informant's Name/Relationsh	nip (Type, Print)		19b. Maili	ng Address (	Street and Num	ber or Run	al Route Number	City or 7	Town, State,	Zip Code)	
<u> </u>	ith ar ith ar 27 is trau		Vantage House			5400	) Vant	age Poi	nt Ro	ad Colum	nhia	MD 3	21044	
a)	1 and Health tem 27 other tr		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name	e of				ation - City or		
<u> </u>	Pages nent of int: If it iny or o		1 ☐ Burial 2 ☐ Cremation  4 ※Donation 5 ☐ Other (S)		m State	cemetery, crei	matory or our	ner place)		i				
Бащтог	permit. Page Department of Important: If eny injury or once.		21. Signature of Euneral Service		2/-	2	2. Name and	Address of Fac	ality					
n n	permi Depa Impo eny it		annal	7. Mades	DATOREDI	r 81	tate A	natomy	Board	1 <sup>655</sup> W.	Ba1t	imore	Street	
	*		23a. Part1. Enter the disease, or	complications tha	t caused the deat								Approximate	в
			shock, or heart failure. List Immediate Cause (Final	only one cause or	ach line.	4A.							Interval Bety Onset and D	
	Physician /Medical		disease or condition resulting in death)	_ a	Velinny	4							DAY	
	Examiner			ue t	o (or as a consec	(Lance of):	12	mintin					100	
		<u>_</u>	Sequentially list conditions, if any, leading to immediate	b. Due t	o (or as a consec	uence of):	Gen	rum Imm					900	
Т	ted	n lu	Cause (Disease of injury											
	be executed ician and burial-transit	Examiner	that initieted events resulting in death) Last	C. Due !	o (or as a consec	quence of):								
) (9/	te be executed sysician and se burial-transit	calE												
289	ž × 9			0										
	certil Iding Ise a	/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes,	outcome of pregna	ancy					23	d. Date of de	livery	
ROX	atter	clar	in the past 12 months?		e birth 2 Fete gnant at time of c		⊒Ectopic pre ⊒ Other (spe					Month	Day Y	/ear
o.	that the death certifical led by the attending phi detached for use as th	Physician/Med	1 □ Yes 2 Ø No 9 □ Unknown	9□ Unl										
7	The law requires that the death certifica tle has been signed by the attending ph page 2 should be detached for use as th	y P	Part II. Other significant condition	ins contributing Ic	death but not res	sulting in the u	inderlying ca	use given in Pai	rt I.	23e. Did tol	bacco use	e conIribute t	o the cause of d	leath?
SD.	uires n sign	d by	Moerta	mm						1 □ Y	es 2 🗆	No 3□P	robably 4 🕮	Jnknown
Vital Records,	w require been si should I	Completed	10							24a. Was a	n	24b. Were a	ulopsy findings a	available
Ě	he la e has ge 2	m d								autops	med?	death?		ause of
ē		e Co	25. Was case referred to medical					ae Dia	on of Deat	1 ☐ Yes		1 🗆 Yes	2 □ No	
	Physicien: The faw this certificate has braid director, page 2 s	o Be	examiner?	Hospital:	☐ Inpatient 2☐	ER/Outpatie	at 3 🗆 DO	Other		ome 5 Reside		Other (Soc	rcify)	
o	Phy this ald	<b>-</b>	27. Manner of Death	28a. Da	te of Injury	28b. Time o		Bc. Injury at Work?	rtursing ric	28d. Describe ho		- ' '	cny)	
0	ding th. Afte	tlor	1 ☑Natural 5 ☐ Pendin 2 ☐ Accident investi	9	onth, Day Year)	Injury	м	Work? 1 ☐ Yes 2	□No					
Division	Atten dea ctor y the	Certification:	3 ☐ Suicide 6 ☐ Could	not be 28e. Pla	ice of Injury - At h	ome, farm, st	reet, factory,	office		28f. Location (S	treet and	Number or R	ural Route Num	ber,
á	afte Dir din b	erti	4 Homicide	bu	ilding, etc. <i>(Speci</i>	ny)				City or Town	i, State)			
	To the Hospital or Attending I within 24 hours after death.  To the Funerel Director: After completely filled in by the funer		29a. Certifier 1 Certifyir	g Physician: To	the best of my kn	owledge, dea	th occurred a	at the time, date	and place,	and due to the c	ause(s) a	nd manner a	s stated.	
	n 24 l n 24 l ne Fu	edical	(Check only 2 Medical one)	Examiner: On the and m	basis of examination anner stated.	ation and/or ir								)
	Withir To the comp	Me	29b. Signature and title of gertifie	г			29c.	License numbe	er .	2	9d. Date	signed (Mon	th, Day, Year)	
)	-	1	1 Xachia	WW				1) - 54	764		11/20	1/44		
			30. Name and address of person				, Print)		0 : -	α.	0	01	E a a	
			HBu2 D	1000m	, MUS	110	55 6	1the	stuy	int 114	Col	eusir	(VII)	
	Sta Regist		31. Date filed (Month, Day, Year)	2004	. Registrar's Sign	ature	200	eks/		ur AL				

		1	State of Maryland / Department of Health a  1- For State Sta		l Hygien Reg. N	2001	3031.1
			Decedent's Name (First, Middle, Last)		e of Death		3. Time of Death
	Physicia /Medic	al	Beative Jackson	1:	2 6	6 04	5:50 PM
	Examin	er	4a. Facility Name (If not institution, give street and number)  DLD COURT NURSING CENTER  RUNDAILS		4	Baltin	
	Funeral Director		5. Social Security Number 6. Sex 1 Months 1 Mont	Min. (Mo.	e of Birth onth, Day, Yea	9. Birth	nplace (State or Foreign untry) MD
	and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	e Maryi 3a-f sho	Director	MD Baltimore Randallstown				1 ☐ Yes 2 ☑ No
	h with th	al Dire	10e. Street and Number  SH2 OLD COURT ROAD  10f. Zip Code  21135	3	10g. (	Citizen of What Co	untry?
920	be filed within 72 hours after death with the Maryland ital Hygleno. Id other than "natural", or items 23a or 28a-f show avant, the Medical Examinar must be notified at	by Funeral	11. Marital Status  1 SAvever Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 SAvever Married 2 Married  1 SAvever Married 2 Married  1 Savever Married 2 Married  1 Married Forces?  1 Savever Married 2 Married  1 Savever Married 2 Married  1 Savever Married 2 Married  1 Married Forces?  1 Savever Married 2 Married  1 Savever Married 2 Married  1 Savever Married 2 Married  1 Savever Married 2 Married  1 Savever Married 2 Married  1 Savever Married 2 Married  1 Savever Married 2 Married  1 Savever Married 2 Married  1 Savever Married 2 Married  1 Savever Married 2 Married  1 Savever Married 2 Married  1 Savever Married 2 Married  1 Savever Married 2 Married  1 Savever Married 2 Married  1 Savever Married 2 Married  1 Married Forces Married  1 Married Forces Married  1 Married Forces Married  1 Married Forces Married  1 Married Forces Married  1 Married Forces Married  1 Married Forces Married  1 Married Forces Married  1 Married Forces Married  1 Married Forces Married  1 Married Forces Married  1 Married Forces Married  1 Married Forces Married  1 Married Forces Married  1 Married Forces Married  1 Married Forces Married  1 Married Forces Married  1 Married Forces Married  1 M	n, Puerto Rican, e	s or No- etc.)	14. Race - Ame Black, White Specify: [2]	e, etc.
21215-0036	within 72 ho ane. than "natur	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  12th CWALL  16a. Decedent's Usual Occupation (Give kind of work done during mos life. DO NOT use retired)  HOUSEKEEPE		16b.	Kind of Business/	
	bed tal	Be	17. Father's Name (First, Middle, Last)  18. Mother	er's Name (First,	Middle, Maide M A	en Sumame)	
Maryland	ges 1 and 2 should tof Health and Men If Itam 27 is marka or other traumatic	၉	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number 19b. Mailing Address)	er or Rural Route		•	Tip Code) 21163
Baltimore, I	Pages 1 and 2 nent of Health int: if Itam 27 iry or other tri		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 12.11.0		Location - City or and all	Town, State Stown, MD
Balti	permit. Pag Department important: I any injury o		21. Signature of Funer Reervice Licensee  22. Name and Address of Facility  23. Name and Address of Facility  24. Name and Address of Facility  25. Name and Address of Facility  25. Name and Address of Facility  26. Name and Address of Facility  27. Name and Address of Facility  28. Name and Address of Facility  29. Name and Address of Facility  21. Signature of Funer Reevice Licensee	ene tur Natil Pi	reral S	Services	MD 21229
ı			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or head failure. List only one cause on each line.  Immediate Cause (Final	cardiac or respir	atory arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical Examiner		disease or condition resulting in death)  a				
	36.	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events b. Due to (or as a consequence of):				
o,	ate be executed hysicien and the burial-transit	Examiner	resulting in death) Last  C				
68760	ficate be ex physicien s the buria	edical	d				
.O. Box (	The law requires that the death certificate be executed to the as been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		_	23d. Date of del Month	ivery Day Year
<u>α</u>	w requires that the de been signed by the a should be detached f	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I	1. 23		\ /	the cause of death?
Il Records,	sician: The law requ ; certificate has been irector, page 2 shouk	Completed			a. Was an autopsy performed Yes 2	prior to d	topsy findings available completion of cause of 21XNo
of Vital	Physician: rthis certific ral director,	o Be	examiner? Other	e of Death <i>(Chec</i> ursing Home 5		6 □Other (Spec	city)
on of	ding Phys h. After this funeral di	Ion: T	27. Manner of Fath 1 Natural 5 Pending 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Date of Injury 28b. Time of Injury 28c. Injury at Injury 28c. Injury 28c. Injury at Injury 28c. Injury 28c. Injury at Injury 28c.	28d. De		jury occurred	
Division	or Atten after deatl Director: in by the	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide   28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Loc	cation (Street y or Town, Sta	and Number or Ru ate)	iral Route Number,
	e Hospital 24 hours a Funaral letely filled	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date an and manner: On the basis of examination and/or investigation, in my opinion, dea and manner stated.				
	To the within 2 To tha comple	Me	29b. Signature and title of certifier  29c. License number		29d. [	Date signed (Month	h. Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1/0.5.	10 1	12/07	109
	S.	to	31. Date filed (Month, Day, Year)  32. Registrar's Signature,	· KUI	gis /l	ues, r	W 07/17
	Sta Regist		DEC 1 3 2004 have & sports		-		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Ragistra Rag. No. Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) **Physician** 21:25 M TORDAN OSEPHINE DECEMBER 8,2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE, MARYLAND JOHNS HOPKINS BAYVIEW MEDICAL CENTER If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 □ M 2 🔀 F VOR Director 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show Examiner must be notified at 1 No 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 0 Items 23g Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 2 No 1 Never Married 2 Married Yes 1 Yes 2 No ö Specify: β If Yes, Give Year or Dates: 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
(fig. DO NOT use retired) 16b. Kind of Business/Industry event, the Medical 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden 17. Father's Name (First, Middle, Last) Be )illiams 2 other traumatic 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nethod of Disposition

Burial 2 Cremation 20b. Place of Disposition cometery, cremator 3 Removal from State ö permit. Page Department of Important: If any injury or once. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ADENOCARCINOMA METASTATIC PANCREATIC Due to (or as a consequence of) 5 YEARS CEREBIZOVASCULAR ACCIDENT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Examiner for use as the burial-transit HYPERTENSION Due to (or as a consequence of) attending physician IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 \(\sum \) Yes 2 \(\sum \) No 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform

**Physician** /Medical Examiner

the Maryland

death

filed within 72 hours after

Baltimore, Maryland 21215-0036

funeral director, page 2 should be ģ filled

The law requires that the death certificate be executed

Box 68760.

P.O.

Division of Vital Records,

To the Hospital or Attanding Physician:

death.

after death Director:

within 24 hours a To the Funaral L

completely

After

Be Completed Medical Certification: To

25. Was case referred to medical examiner? Hospital: 2X No 1 🗀 Yes

27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 - Homicide

28a. Date of Injury (Month, Day Year)

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury at Work?

1 ☐ Yes 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 📆 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 Yes

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

26. Place of Death (Check only one)

2 X No

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29a Certifier

RES-000

29c. License number

Other:

2 No

29d. Date signed (Month, Day, Year) DECEMBER 8, 2004

4940 EASTEILN AVENUE

BALTEMOIRE, MARYLAND 21224

1 Yes

2X No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHNS HOPKINS BAYVIEW MEDICAL CENTER SUZYAPRASAD

more

State Registrar

32. Registrar's Signature

31. Date filed (Month, Day, Year) DHMH 17 Rev 1/2001

Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12/13/04 TT State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar 00 ls Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 12 Day Year **Physician** 2 John L. Jones 2004 11:36a /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bel Air
If Under 1 Year If Under
Wonths Days Houre Upper Chesapeake Med. Center Harford 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1**⋈** M 2□ F Months 213-52-3647 55 Director 3-12-49 Md. Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Yes 2 □ No Director Baltimore Md. NA 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with to Department of Health and Mental Hygiene. If them 27 is marked other than "natural", or items 23a or 21 any nigury or other traumatic event, the Medical Examples 200.00. 21218 USA 2621 Kirk Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black þ If Yes, Give Year or Dates: 3 ₩Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry entary/Secondary (0-12) College (1-4or 5+) Good Samaritan Hosp. Supervisor-Housekeeping 12th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mildred Lomax Jones John 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21040 1852 Grempler Way, Edgewood, Md. Son Anthony Jones 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State

'4 □ Donation 5 □ Other (Specify) Randallstown, Md. 12-8-04 King Mem. Pk. 22. Name and Address of Facility 21202 21. Signature of Funeral Service Licensee Baltimore. Md. March F. H. East 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Cardiorespiratory Physician 5 munit /Medical - small cell lung cancer **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician Box 68760 Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown been signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ pe Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 XNo 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2€ R/Outpatient 3 ☐ DOA Other: 4 Nursing Home ome Sidence 6 Other (Specify)
28d. escribe how injury occurred 1 ☐ Yes 2 No 2 this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: After 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗍 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month. Day, Year) 29c. License number 29b. Signature and title of certifier 16587 ia an 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) J Medica Chang mooscole 31. Date filed (Month Day, Year) 32. Registrar's Signature State Registrar DEC 1 3 2004

DHMH 17 Rev 1/2001

ORIGINAL

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

		-	For State Registrar	State of Mar		tificate of I			2004	39344
	Physicia	ın	1. Decedent's Name (First, Middle, Las Joseph Johns	,				2. Date of Death Month DECEMBER	Day Year 3,2004	3. Time of Death 1:30p M
	/Medic Examin		4a. Facility Name (If not institution, give 540 WINSTON AVENUE	street and number)		4b. City, Town, or	Location of Death	DECEMBER	4c. County of Deat	h
	Funeral		5. Social Security Number 6. Se		In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birtl	hplace (State or Foreign
	Director		215-48-3463	M 2□ F	54 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, ) Sept 10,	1950 Må	ryland
	iryland show		10a. State 10b. County	1	Oc. City, Town or Lo					10d. Inside City Limits 1 ▼ Yes 2 No
	the Ma 28a-f	recto	MD  10e. Street and Number		Dalu	imore		100	J. Citizen of What Co	
	th with 23a or ust be	al Di	540 Winston Avenu	ue #1			21212		USA	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic avant, If a Marical Exactination at 2008.	by Funeral Director	11. Marital Status  1 🖔 Never Married 2 C Married  3 C Widowed 4 C Divorced	12. Was Decedent Ev. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2X No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: b	
Maryland 21215-0036	in 72 ho "natur	Completed	15. Decedent's Ed (Specify only highest grad	de completed)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of work	ing	6b. Kind of Business/	Industry
212	ed with ygiene. nar thar t, II v A	Com		College (1-4or 5+)		intenance		(5)	private 1	nomes
and	d be file	Be	17. Father's Name (First, Middle, Last)  Joseph Alexande					e (First, Middle, Ma erine Mil		
2	should nd Me mark matic	ဥ	19a. Informant's Name/Relationship (7		19b. Mailin	ng Address (Street			City or Town, State, 2	Tip Code)
	nd 2 alth ar 27 is 27 is ir trau		Cheryl Watson/sis	ster	2011	E. 31st	Street Ba	altimore,	MD 21218	
Baltimore,	Pages 1 a ment of Hez ant: If itam ury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 📉 Other (Specify		<b>–</b>	sition (Name of natory or other plac		Date 20	c. Location - City or	Town, State
Balt	permit. Departimport Import any inj		21. Signature Superal Service Licen	Wagley, Mi	St Ba	Name and Addre tate Anat altimore,	omy Board MD 2120	655 W. 1	Baltimore	Street
			23a. Part Enter the disease, or comp shock or heart failure. List only	plications that caused the	e death. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death
	Fnysician /Medical	7	Immediate Cause (Final disease or condition resulting in death)	W	oscle rot	-(C (a)	rauvasi	UKY 9	isesse	
P	Examiner		Sequentially list conditions.	b						
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or se's t	ronsequaricà org:					
, , ,	tificate be executed g physician and as the burial-transit	і Ехаг	that initiated events resulting in death) Last	Due to (or as a	consequence of):					
68760,	icate b physic s the b	edicai		d						
.O. Box (	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	/		23d. Date of deli Month	ivery Day Year
٥.	w requires that is been signed by should be deta		Part II. Other significant conditions of	ontributing to death but	not resulting in the u	nderlying cause giv	en in Part I.		cco use contribute to	C.
Records,	iclan: The law req certificate has beer rector, page 2 shou	Completed by						24a. Was an autopsy performe	prior to d	topsy findings available completion of cause of
Vital	clan: artifica	Bec	25. Was case referred to medical examiner?					h (Check only one)		
of V	Physician: this certific ral director,	2	XX Yes 2□No	Hospital:	2 ER/Outpatier			ome 5 Residen 28d. Describe how	ce 6 Other (Spec	cify)
no	ng lfe	tion	27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day		Wor	k? Yes 2 □No	200. Describe non	injury occurred	
Division	To the Hospital or Attanding Physician: within 24 hours after death.  To the Funeral Diractor: After this certific completely filled in by the funeral director.	Certification;	3 Suicide 6 Could not by determined		y - At home, farm, str (Specify)	reet, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	iral Roule Number,
	e Hospita 124 hours le Funera letely fille	edicai C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exert	ysicien: To the best of niner: On the basis of e and manner state	xamination and/or in	h occurred at the tir vestigation, in my o	me, date and ptace, opinion, death occur	and due to the cau red at the time, dat	se(s) and manner as e and place, and due	stated. to the cause(s)
)	To the To the comp	Me	29b. Signature and title of certifier  Zaluiu	Mal A	19-	29c. Licens			Date signed (Montle CEMBER 4, 2	
			30. Name and address of person who ZABIUCLA		ath (Item 23a) (Type,	Print) PENN STR	REET, BALT	IMORE, MAR	YLAND 2120	)1
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar	s Signature	Sparks	/			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Vear **Physician** ELIZABETH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner CARROLL WESTMINSTER CARROLL HOSPITAL CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth | Months | Days | Hours | Min. | AUGUS F<sup>ay</sup>3 V<sub>4</sub> 1 922 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Months MARYLAND 1 M 200 F 82 217-18-3869 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes ŽQNo Director WESTMINSTER MARYLAND CARROLL 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21157 UNITED STATES 225 FROCK DRIVE APT 111 or Itams 23a Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status e filed within 72 hours after de Il Hygiene. other than "naturel", or itam Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify. ٥ If Yes, Give Year or Dates: WHITE 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC HOMEMAKER is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be front of Health and Mental I sut: If item 27 is marked of MARIE ALVERTA LOCKARD FRANKLIN E. BUTTERBAUGH 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 225 FROCK DRIVE APT.111, WESTMINSTER, MD 21157 WILSON B. HORSEY/HUSBAND 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition XXX Burial 2 Cremation 3 Removal from State ö MEADOW BRANCH CEMETERY 12/15/04 WESTMINSTER, MARYLAND permit. Page Department of Importent: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
MYERS-DURBORAW FUNERAL
91 WILLIS STREET, WES 21. Signature of Funeral Service RAL HOME, P.A. WESTMINSTER, MD 21157 Approximate Interval Between Onset and Death Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause or each line. 23a. Part Immediate Cause (Final disease or condition resulting in death) Physician /Medical as a consequence of) nd Fallver Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or ir jury that initiated events resulting in death) Last Examiner the burial-transit the attending physicien and Due to (or as a consequence of): P.O. Box 68760 certificate be Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 No 1 Yes Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 No 1 Inpatient 2 1 Tyes 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature ag 0 who completed cause of death (Item 23a) (Type, Print) ame and address of 18 Weshings 016 32. Registrar's Signature State Registrar

			1 - State Registrar	of Maryland / [		artment rtificate			and Me		iene •g. No 20 (	3934	6
	Physicia	an	Decedent's Name (First, Middle, Last)	1					}.	2. Date of Dea Month	th Day	3. Time of Death	-
	/Medic	al -	Dorothy Mildred 1  4a. Facility Name (If not institution, give street and n			4b. City, To	own or	Location o		Dec	4c. County of	10 Death	М
	Examin	er	4144 Beachwood Road	umb <del>a</del> ry				imore				timore	
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs. last bin	thday) Yrs.	If Under 1 Months	Year_ Days	If Under: Hours	Min.	8. Date of Birth (Month, Day Nov. 12	Year)	9. Birthplace (State or Fore Country) Maryland	sign
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	n or Lo	cation						10d. Inside City Limi	iits
	e Man Sa-f sh tilliad	ctor	Maryland Baltimore			Balt	timo	re				1 □ Yes 2 ☑ N	No
	with th	Director	10e. Street and Number 4144 Beachwood Road			10f. Zip C		1222		1	0g. Citizen of W	/hat Country? S.A.	
	death	Funeral	11. Marital Status 12. Was De	cedent Ever in U.S.	13.	Was Decede			gin? (Spec	cify Yes or No- lican, etc.)	14. Race	- American Indian,	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Marical Examinat mast be matified at	þ	A med d  1 Never Married 2 X Married 1 Yes. 3 Widowed 4 Divorced Year or	2 X No Give		iYes, specin 1 ☐ Yes 2[		Specify:	i, Pueno H	ncan, etc.)	Specify:	k, White, etc. White	
5-0	72 hc	eted	15. Decedent's Education (Specify only highest grade completed		Dece (Give	dent's Usual kind of work DO NOT use	Occupa done d	ition Juring mos	t of workin	g	16b. Kind of Bus	siness/Industry	
121	filed within Hygiene. Ither than ont, It e Me	Completed	Elementary/Secondary (0-12) College 9th Grade	(1-4or 5+)		emaker		,			Own H	ome	
nd	0 = 0 %	Be C	17. Father's Name (First, Middle, Last)	_							Maiden Sumame	9)	
Maryland	Men Men arke	2	Francis Emory Scart		Moilie	an Address /	(Street 2		Anna	Uzmed	r, City or Town, S	State Zin Code)	
Mai	12 s h ar 7 ls trau									rry Hal		21128	
ore,	ss 1 and 2 of Health item 27 I		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from	20b. Place of								City or Town, State	
Baltimore,	Pages Iment of I tant: If it		* 4 ☐ Donation 5 ☐ Other (Specify)	Most H								re, Maryland	
Ball	permit. Page Department Important: Il any injury o		21. Signatur / June 11. Service Licensee							munek F ltimore	uneral	Homes 1236	
			23a. Part1. Enter the disease, or complications that shock, or heart faiture. List only one cause or	t caused the death. Do i								Approximate Interval Between	
	Physician											Onset and Death	
	/Medical Examiner		resulting in death)  Due t	JDC A72 Di o (or as a consequence DV > 1 - 1 o (or as a consequence	of):				1	4.5.0		5 10 100	
		ē	Sequentially list conditions, b. Due to	o (or as a constinent)	3	6/1	101	) "	~ 3 ×	225		2017	-
	cuted	Examln	cause. Enter Underlying Cause (Disease or injury that initiated events  c.	-7,000,000									
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Box 68760	<u> </u>	edlcal	d										
XO	leath certifica attending phi d for use as th	an/M	23b. Was decedent pregnant	outcome of pregnancy birth 2 Petal death	3 [	Ectopic pre	gnancy				23d. Date	e of delivery oth Day Year	
	ne deal the att	Physician/Med		gnant at time of death		Other (spec					Mon	iti Day 16a1	
P.O.	res that the de signed by the a be detached t	by Ph	Part II. Other significant conditions contributing to	death but not resulting in	n the u	nderlying cau	use give	n in Part I		23e. Did to	bacco use contri	ibute to the cause of death?	,
rds	w requires been sign should be	ed b	Advanced rh	e une to 10	4	art	hr	itis		1 🗆 Y	es 2 🗆 No	3 Probably 4 Unknow	wn
Vital Records,	ne law re has be ge 2 sho	Completed	esteoporas	S				<u>-</u>		24a. Was a autop: perfor	sy p	Vere autopsy findings availal rior to completion of cause of eath?	ible of
ai H	Physician: The la rthis certificate has ral director, page 2		OS War and be madical					00 Bl	of Dooth	1 ☐ Yes	2 No 1	Yes 2 No	
í Vit	ysicia. Is certii directo	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No Hospital: 1	☐Inpatient 2☐ER/Oι	utpatie	nt 3 DOA	Othe			(Check only or ne 5 X esid	ence 6 □Othe	or (Specify)	
n of	ding Phi h. After thi funeral		27. Manner of Death 28a. Da 1 ☐ Ratural 5 ☐ Pending		Time o Injury		c. Injury Work			8d. Describe h	ow injury occurre	ed	
Division	ttendl death. stor: A	icatl	2 Accident investigation	ce of Injury - At home, fa	arm st	M reet factory		Yes 2□		8f. Location (S	treet and Numbe	er or Rural Route Number,	_
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	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical (	29a. Certifier 1 PCertifying Physician: To 1 (Check only one) 2 Medical Examiner: On the and m										
	To the within To the company	Σ	29b. Signature and title of certifier	Mahre	7/	29c.	License	number	-10	7	29d. Date signed	(Month, Day, Year)	Ĺ
,	in		30. Name and address of person who completed ca	use of death (Itom 22a)	(Type	Print		973	, ( )	1	DEC	9 ( 2014 2122 Alt MD	
	10		Matthew Me	Registrar's Signature	L	1943	٤	AST	-62	s Ar	e 3	hlt mo	1
	Sta Regist	ate rar	DEC 1 3 2004	Description (6)	,	Span	Ks	, 					

			i lease i	State of Marylan					-	aiene	,	
			For Stete Registrer	otato o. marytari		rtificate				Reg. No	104	3931.7
	- 4		1. Decedent's Name (First, Middle, Last)	1600					2. Date of De	eath Day 77	Year	3. Time of Death
	Physici /Medic		SHAU-TEL	1 KAO					Decen	ber 8	2004	11-CO M
	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, T	own, or Lo	cation of Dea		4c. Cour	ty of Death	
			Howard Co	ounty General Hospi 7. Age (In yrs. I		If Under 1	Year If	Under 24 Hr	olumbia  S. 8. Date of Bir	rth		vard lace (State or Foreign
	Funeral Director			M 2□F 89	V			tours Mir	n. (Month, Da	ay, Year)	Coun	place (State or Foreign htry)
	ס		Usual Residence of Decedent						August 1	2, 1915	1.	China
	arylan show	_	10a. State 10b. County	10c. City	, Town or Lo	ocation					1	0d. Inside City Limits 1 ☐ Yes 2 No
	188-f	Director	Maryland How  10e, Street and Number	ard		10f. Zip 0		ımbia		10g. Citizen o	f What Cour	
	with t					Tot. Zip c	2000	21044		.09.01.2011	U.S.	
	d within 72 hours after death with the Maryland jiene. r than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at	Funeral	11239 Powder Run Rd.	2. Was Decedent Ever in U.	S. 13.	Was Decede	nt of Hispa		(Specify Yes or No arto Rican, etc.)	o- 14. R	ace - Americ	can Indian,
9	or Ite	Ē	1 Never Married 2 Married	Armed Forces?  1 Yes 2 No If Yes, Give			\/	nexican, rue Specify:	ano mican, etc.;	Spec	lack, White,	
003	ural',	d by	3 Widowed 4 Divorced	Year or Dates:								Asian
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12	within 72 iene. • than "nai the Wedic	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 4	•			I Engine	er		rieeia	ance
b	othe	Be C	17. Father's Name (First, Middle, Last)				18	. Mother's N	ame (First, Middle	, Maiden Sum	ame)	
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Maryland 21215-0036	and and ls m		19a. Informant's Name/Relationship (Type	oe, Print)		,			Rural Route Numb			Code)
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יסר	00-		1 Burial 2 □ Cremation 3 □ R		emetery, crei	matory or oth	er place)	1	2/10/2004			Maryland
Baltimore,			* 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License	e molar		ia Memo 2. Name and		K	2/10/2004	Cia	iksville,	iviai yiailu
Ba	permit. Departr Imports any inj				0	Sla	ck Fun	eral Hon	ne, P.A.	H City MD	21042	
			23a. Part 1. Sater the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the death	n. Do not en	ter the mode	of dying, s	uch as cardi	ac or respiratory a	arrest,	21043	Approximate Interval Between
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	/Medical		resulting in death)	Due to (or as a conseq	uence of):		N R CI	CESS			2	Coolie
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	bed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	SED CI C	dence or).						B	weels
	be executed ician and burial-transit	xar	that initiated events resulting in death) Last	Due to (or as a consequence	uence of):							
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68	rtificat ng phy as th		IF FEMALE:								<u> </u>	
Вох	death certifica e attending ph ed for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1□Live birth 2□Feta	I death 3	□Ectopic pre					Date of delive Month	Day Year
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Records,	uires I sign	d by	DEMENTA						10	Yes 2☐Mo	3 Prob	bably 4 Unknown
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Re	The la	Completed	DIARFITES						auto perfe	ormed?	death?	2 No
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n o	ing After une	ion:	27. Manner of Death 1 □ Matural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	of 28	c. Injury at Work?	2 □No	28d. Describe	how injury occ	urrea	
Division	tan leat lor: the	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At he	ome, farm, st						nber or Rura	I Route Number,
Div	in the second	Certification:	4 ☐ Homicide determined	building, etc. (Specif	y)	. ,			City or To	wn, State)		
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by			sicien: To the best of my kno ner: On the basis of examina								
	he He in 24 he Fu	edical	one)	and manner stated.	don and/or in				corred at the time.			
	To the within 3	Σ	29b. Signature and title of certifier	MA		29c.	License ni	umber		29d. Date sign	nea (Month,	At 1 . AL
7	/		1 Knowled	11. 7		L	2	17/8	2: 1	Dear	1=	5- 6007
	5		30. Name and address of person who co	impleted cause of death (Item	1201 (Type,	. Print) 3	OO F	194au	ory pe	, su	4	9
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture							
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ORIGINAL

			1 - For State Registrer	State of Maryland /		artment of He tificate of D			giene Reg. No.2 ()	104	3931.8
	Physic /Medi			ewis				2. Date of Dea	100/ C	Year Y	3. Time of Death
	Examir Funeral	ner	4a. Facility Name (If not institution, give st 1000 PLEASANT  5. Social Security Number 6. Sex		-	4b. City, Town, or L	Ville If Under 24 Hrs.	8. Date of Birti	B		olace (State or Foreign
	Director		Usual Residence of Decedent	w 2007 72	Yrs.	Months Days	Hours Min.	(Month, Da) 04 · 13	, Year) 19132		place (State or Foreign ntry) PA
	the Maryla 28e-f shov	Director	10a. State  MD  Ba Him  10b. County  The street and Number	ore las		ville			10g. Citizen of		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	within 72 hours after death with the Maryland sne. than "naturel", or items 23e or 28e-f show ta Medical Evaminar must be notified at	Funeral Dir	1000 Pleasant Va	. Was Decedent Ever in U.S.	13. <u>V</u>	10f. Zip Code  ZI  Vas Decedent of His Yes, specify Cuban,	228 panic Origin? (Sp		( 14. Ra	S.A	can Indian,
9000	72 hours after "naturel", or fte	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ② Divorced	Armed Forces? 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates:	1	☐ Yes 2 🔀 No	Specify:	Hican, etc.)	Specia	ry: BL	ACK
Maryland 21215-0036	filed within 72 ho Hygiene. Ither than "natur ent, I'm Medicall	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)		(Give I life. D	ent's Usual Occupation of work done du NOT use retired)	rin <b>g</b> most of work	ing	16b. Kind of E	Susiness/In TH IN.AN	CARE
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re, Mar	is 1 and 2 sh of Health and item 27 is m other treum		19a. Informant's Name/Relationship ( <i>Typ</i> WILLIAM A. LEW) 20a. Method of Disposition	3, JR./50N 11	D D D	Address (Street and PIECSAN+ ition (Name of	Valley 1	Drive C	r, City or Town A TOUSVI 20c. Location	lle M	D 21228
Baltimore,	t. Page rtment o rtent: If		1 Surial 2 Cremation 3 Re 4 Donation 5 Other (Specify) 21. Signal re of Funeral Service License	moval from State cernete	ary, cram	atory or other place)	12.1	5.04	Baltin	nore	,MD
	Proviociant /Medical Examiner		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	utions that caused the death. Do cause on each line.  Due to (or as a consequence	not ente	The mode of dying,	such as cardiac of	or respiratory arr	e Balt	imore	Approximate Interval Between Onset and Death
8760,	certificate be executed nding physician and use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Einer underrying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a consequence							
O. Box 6	the death certify the attending ched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 4□Pregnant at time of death 9□ Unknown				te of delive onth	ery Day Year		
ords, P.	The law requires that ate has been signed by age 2 should be deta	by	Part II. Other significant conditions contr	buting to death but not resulting	in the und	derlying cause given	in Part I.		pacco use cont es 2□No		ne cause of death?
Vital Records,		Completed						24a. Was a autops perform	y ned?	prior to cor death?	psy findings available inpletion of cause of
Division of Vit	Phys this ral dii	ation: To Be	25. Was case referred to medical examiner?  1  Yes 2 No Ho  27. Manner of Death  Natural 5 Pending  2 Accident Investigation		utpatient Time of Injury	3☐ DOA Other: 28c. Injury a Work?	4   Nursing Hor		ence 6 Oth		1)
Divis	or At titer of Direction by	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	arm, stre	et, factory, office	-	28f. Location (St. City or Town	reet and Numb ı, State)	er or Rura	l Route Number,
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	Medical	29a. Certifier (Check only one)  1 ☐ Certifying Physic 2 ☐ Medicel Examine 29b. Signature and title of certifier	ien: To the best of my knowledg r: On the basis of examination ar and manner stated.	e, death nd/or inve	occurred at the time, estigation, in my opin 29c. License n	ion, death occurre	ed at the time, da	ause(s) and ma ate and place, 9d. Date signe	and due to	the cause(s)
	γ. γ		> Puspanis	Deleted cause of death (Item 23a)	/Tuna P	047			_		
	Sta	te_	31. Date filed (Month, Day, Year)	32. Registrar's Signature	T. 9A	re Pure	Z. M	Then	E M	N 5	120
DH	Registr MH 17 Rev 1/20		DFC 1 3 2004	Alexand for	9	doubs					

ORIGINAL

	Wayne 04-795	Li <sub>g</sub> 2	Amend ite	nd item#23a,27,28a-f. e Type or Print in Black li em#7,20b, perFh,G85 State of Maryland, Dep	perME, G839 ndelible lnk./ 12/13/	,1/31/05 Ensure All ( )4 TT	TT Copies Ar	e Legible.	
	AKG		1 - State Registrar  1. Decedent's Name (First, Middle,	Ce	ertificate of D	eath 2.	Reg.	A	3 0 3 1 0
35	/Medio Examir Funeral		4a. Facility Name (If not institution, § 5024 Dickey Hill 5. Social Security Number 6	give street and number)	4b. City, Town, or Lo Baltimore	ocation of Death	Date of Birth	4c. County of Dea	
5	Director		214-86-8679  Usual Residence of Decedent  10a. State 10b. County	10 YM 2□F 34 Yrs.		Hours Min.	PRIL 19,1	9u8 M	10d. Inside City Limits
	ath with the Marylan 23a or 28a-f show	rector	10e. Street and Number	1 // .	IMORE 10f. Zip Code		10a.	Citizen of What Co	1 Yes 2 No
9	rs after death with '', or Items 23a or	Funeral Director	50 14 DICKE	d 1 ☐ Yes 2 ☐ No	. Was Decedent of Hisp If Yes, specify Cuban,			14. Race - Ame Black, Whi	erican Indian,
21215-0036	2 hour	Completed by	3 ☐ Widowed 4 ☑ Divorced  15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed) (Giv	edent's Usuaf Occupation of Work done during DO NOT use retired)	ing most of working	16b	Specify: L.  Kind of Business  DISA	
Maryland 2	2 should be filed within and Mantal Hygiene. is marked other than reumatic event, It.e.M.	To Be Co	17. Father's Name (First, Middle, La	LIGHTNER		3. Mother's Name (F	irst, Middle, Maid		/
Baltimore, Mar	permit. Pagas 1 and 2 should ba filed within 7: Department of Health and Mantal Hygiene. Important: If item 27 is marked other than "n any injury or other traumatic event, If a Madi Once.		19a. Informant's Name/Relationship  MSV LIGHTNEK—  20a. Metrod of Disposition 1	BAKER   SISTER   500 Place of Disposition State   Signature   Sign	ling Address (Street and H SHTK W  position (Name of ematory or other place)  T k  22. Name and Address of	12/16	12001b	TIMORE Location - City or HTIMORE	Mp 2/239 Town, State
,	Medical Examiner	dicai Examiner	23a. Part1. Enter the disease, effective shock, or heart failure. Let or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	omplications that caused the death. Do not entry one cause on each line.  a. Narcotic Intoxi Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.		such as cardiac or re	espiratory arrest,	X0 / 1000	Approximate Interval Between Onset and Death
P.O. Box 68760	E O e	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	livery Day Year
ords, P.	w requires that the death cer been signed by the attendin should be detached for use	by	Part II. Other significant condition	s contributing to death but not resulting in the	underlying cause given	in Part I.	1 🗆 Yes	200 3 P	o the cause of death? robably 4 Unknown
tal Rec	ician: The law certificate has l rector, page 2 s	e Completed	25. Was case referred to medicaf		2	6. Pface of Death (C	24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
ivision	or Attending ter death. iractor: Atter ir by the fune	Certification: To B	examiner?  XXYes 2 No  27. Manner of Death  1 Natural 5 Pending investigal  3 Suicide 6X Could no 4 Homicide	t be Spa Place of Injury At home form a	ont 3 DOA Other:  28c. Injury at Work?  1 Yes	4 Nursing Home 28d 2 XNo ur 28f.	5 ☐ Residence . Describe how in	and Number or Ruate) 5024 D	ural Route Number, ickey Hill R
	To the Hospital or Atten within 24 hours after deat To the Funeral Diractor: completely filled in by the	Medical C	29a. Certifier (Check only one)  1☐ Certifying   1☐ Certifyin	Physicien: To the best of my knowledge, dea caminer: On the basis of examination and/or and manner stated.	th occurred at the time, nvestigation, in my opinion 29c. License no O.C.M.I	date and place, and on, death occurred a umber	due to the cause at the time, date a	(s) and manner as	to the cause(s) th, Day, Year)
	n)		30. Name and address of person when the same and address of person address of the same and address of the same address	ho completed cause of death (ftem 23a) (Type					
	Sta Registr		31. Date filed (Month Early 4ar) 3	2004 32. Registrar's Signature	Sparks		ore, ridi	-yranu z	21201

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, L 10:00 PM DECEMBER 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution BATI MORE If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours Months 219-10-7692 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 1 Yes 2 No MD 10g. Citizen of What Country? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: DLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOME IMPROVEMENT 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) WILLIE 9a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAVISITER 145 ur 200. Place of Disposition (Name of cemetery, cremator) or other properties of the property of 20a. Method of Disposition 1 Burial 2 Cremation 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) prosta Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 DUnknown 23e. Did tobacco use contribute to the cause of death? demention 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2□ No autopsy performed? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home

**Physician** /Medical Examiner

Box 68760,

P.0.

Division of Vital Records,

Independent of Health an Importent: If item 27 Is . any injury or other training.

Physician

/Medical

Examiner

Director

Completed by Funeral

**Funeral** 

Director

item 27 is marked other then "neturel", or items 23e or 28e-f show other treumatic event, ite Medical Examinat must be notified at

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant of Health and Mental Hygiene.

the Maryland

Physician/Medical Examiner use as the burial-transit į ģ Completed the funeral director, page 2. Be 2 Certification:

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 🗌 Yes 27. Manner of Death 1 Natural

5 Pending investigation 6 □ Could not be

determined

Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Tes

2 □ No

28d. Describe how injury occurred

Baltimore

28f. Location (Street and Number or Rural Route Number, City or Town, State)

5 ☐ Residence 6 ☐ Other (Specify) ├ OSPICE

29a. Certifier

2 Accident

3 🗌 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 124170

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

838 Hospice

32. Registrar's Signature

Registrar

State

After this

filled in by

within 24 hours a To the Funerel [

**ORIGINAL** 

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of	Marylar	nd / Depa <i>Cei</i>	artmen <i>rtificat</i>			nd Me	ental I	Hygier Reg. i	000	1.	20250
	Physic	an	1. Decedent's Name (First, Middle, La Jeanne L. Lubi	,							2. Date o	Death		Year	3. Time of Death 7:29 A M
	/Medi Examir		4a. Fecility Name (If not institution, given 1417 MOUNT CARMET	Town, or	Location of		- 202		4c. County o	f Death					
	Funeral Director		216-48-2850	ex 7 □M 2XXF	. ,	last birthday) 9 Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of (Month)	Day, Yea	ar)	9. Birthp	place (State or Foreign otry) yland
	r 28a-f show	tor	Usual Residence of Decedent  10a. State 10b. County  MD Baltimo	re	10c. Ci	ty, Town or Lo Parkt								1	0d. Inside City Limits 1 ☐ Yes 2X No
	eth with the	Direc	10e. Street and Number 1417 Mount Carm	al Pond			10f. Zip		1.00			10g.	Citizen of W	hat Coun	ntry?
36	efter des or items miner m	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☒ Divorced	12. Was Deced Armed Ford 1 Tyes 2 If Yes, Give Year or Dat	es? !∭No	1	Was Deced f Yes, spec	lent of His	120 spanic Orig n, Mexican, Specify:	in? (Spec Puerto R	ify Yes or lican, etc.	No-	USA  14. Race - American Indian, Black, White, etc.  Specify: White		
21215-0036	withln 72 hours ene. then "natural', ne Mudical Exa	Completed	15. Decedent's Elementary/Secondary (0-12)	ducation		life. L	kind of wor DO NOT us	rk done d se retired)	uring most		g		6b. Kind of Business/Industry		
and 2	be filed ntal Hygi od other event, I	Be	17. Father's Name (First, Middle, Last John Warren Spa			01	a Ims	auch	18. Mother	's Name (		dle, Maid	ocial security adm iden Sumame)		
Maryland	should and Mer is marke	٦	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)											Code)	
Baltimore, M			Frank Lubinski/former spouse  1417 Mount Carmel  20a. Method of Disposition  1										wn, State		
Baltir			21. Sign are of Euneral Service Licensee State Anatomy Board 655 W. Ball Baltimore, MD 21201											re S	treet
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.   OHVULATIONS  Due to (or as a consequence of):												
68760,	icate be executed physicien and s the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a conseq										
P.O. Box 687	deeth certif e ettending ed for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 2 □ Nnown		h 2∏Feta ntattime of d	I death 3 🗌	Ectopic pro					_	23d. Date Monti		ry Day Year
	200	ρχ	Part II. Other significant conditions of	ontributing to dea	th but not res	ulting in the un	derlying ca	iuse give	n in Part I.						e cause of death?
al Records,	The ate h	Completed									24a. Was an autopsy performed?  DELYes 2 \( \subseteq \) No 1 \( \subseteq \) No 24b. Were autopsy findings as prior to completion of caudeath?				
ion of Vital	aling Phys n. After this funeral dii	ation: To Be	25. Was case referred to medical examiner?  12 Yes 2 No  27. Manner of Death  1 Shatural 5 Pending investigation	Hospital: 1 Ing 28a. Date of (Month,		ER/Outpatient 28b. Time of Injury		Bc. Injury Work	26. Place of 4 Nurs at es 2 No	sing Home	9 5□R	esidence	6XOther		SCENE
Division	or A after Direction by	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place o	f Injury - At ho , etc. <i>(Specif</i>	ome, farm, stre	et, factory	office		28	f. Location City or	n (Street a Town, Sta	and Number te)	or Rural	Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exam	ysician: To the b niner: On the bas and manne	is of examina	wledge, death tion and/or inv	occurred a estigation,	at the time in my opi	e, date and nion, death	place, an	d due to t I at the tim	ne cause( e, date a	s) and mann nd place, an	er as sta d due to	ated. the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier				29c.	License O C	number M E				ate signed (		
			30. Name and address of person who		of death (Item	1 23a) (Type, F	Print) 11	1 PE	NN ST	REET	, BAI	TIMO	RE, M	ARYL	AND, 21201
	Sta Registr		31. Date filed (Month, Day, Year) DEC 1 3 2004	#	jistrar's Signa مراجسوري	ture	Ann	w.,							

			1- State of Man		artment of Health and I rtificate of Death	Mental Hygier Reg. f	2111 L	39353
	Physic /Medi		1. Decedent's Name (First, Middle, Last) RICHARD MASON SR.			2. Date of Death Month December 0	Day Year	3. Time of Death
	Exami		4a. Facility Name (If not institution, give street and number) St. Agnes Hospital		4b. City, Town, or Location of Death Baltimore	-	4c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (№ 21/2 - 20 - 0223 15€M 2□ F Usual Residence of Decedent	n yrs. last birthday) 70 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	ir) Cou	nplace (State or Foreign untry)
	with the Maryland s or 28e-f show	tor		Oc. City, Town or Lo	saltimore			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	th with the 23a or 28e	Funeral Director	10e. Street and Number 2849 W. Mulberry Street		10f. Zip Code 21223	10g. C	Citizen of What Cou	untry?
920	after dea or Items	by	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Eve Armed Forces?  1 Syes 2 No If Yes, Give Year or Dates:	!	Was Decedent of Hispanic Origin? (S if Yes, specify Cuban, Mexican, Puert 1 Yes 2 KNo Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No-	14. Race - Amer Black, White	
21215-0036	CV 00 U	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	(Give life.	dent's Usual Occupation kind of work done during most of wor DO NOT use retired) RE FIGHTER	king	Kind of Business/li	- 4
Maryland 2	be filed ntal Hygi od other event, I	To Be Co	17. Father's Name (First, Middle, Last)  John Oscar Mason		18. Mother's Nam	ne (First, Middle, Maide UNL	en Sumame)	
	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print)  RUSIC L. MASTN / IVI FC  20a. Method of Disposition	19b. Mailir 2840 20b. Place of Dispo	0.107	treet Ba	ito. MD	21223
Baltimore,	t. Page rtment o rtant: If		1 D Burial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License	cemetery, cren	TLIS 12.1	3.04 7	Location - City or T Saltimor	
Ba	Pulysician Depart		23a. Part 1. Enterthe disease, or complications that caused the	51	Name and Address of Facility MUAIN C. GREENE FUR SIMPLE NOTE  SIMPLE MODE of duing such as cardiac	onal rike 1	ies Baltimore	-
			shock, or near failure. List only one cause on each line.	Hemorrh	age - Gastroint			Approximate Interval Between Onset and Death 24 hours
	Examiner	lner	Sequentially list conditions, if any least it immediate cause. Enter Underlying	onsequence of):				Days
,0928	icate be executed physicien and s the burial-transit	dical Examiner	Cause (Disease or Injury that initiated events resulting in death) Last  C. MijoCard  Due to (or as a co		ichon			Months
P.O. Box 68	nding use as	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delive	ery Day Year
	w requires that the death been signed by the atte should be detached for	ed by Pł	Part II. Other significant conditions contributing to death but no Stroke, Patent Foramen ovale	ot resulting in the un	iderlying cause given in Part I. Anemi'a		he cause of death?	
al Records,	: The law re cate has be , page 2 sho	Complet	Hypothyroidism, Ventilator Disseminated Intravascular		dancy,	24a. Was an autopsy performed?	_ death?	opsy findings available impletion of cause of
ion of Vital	To the Hospitel or Attending Physicien: The law within 24 burus after death.  To the Funerel Director: Atten this certificate has completely filled in by the funeral director, page 2	atlon; To Be	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital: 1 Inpatient  27. Manner of Death 1  Actival 5 Pending 2  Accident investigation	2 TER/Outpatient 28b. Time of Injury	04	h (Check only one) me 5 ☐ Residence 28d. Describe how inju		<b>5</b> y)
Division	tel or Atters after de el Directo ed in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury-building, etc. (S	At home, farm, stre	eet, factory, office	28f. Location (Street a City or Town, Stat	nd Number or Rura e)	al Route Number,
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of m 2 Medical Examiner: On the basis of exa and manner stated.	amination and/or inv	occurred at the time, date and place, estigation, in my opinion, death occur	and due to the cause(s red at the time, date an	and manner as s id place, and due to	tated. o the cause(s)
F	A Series	2	29b. Signature and title of certifier  Blandsline Slue, MD		29c. License number		ate signed (Month,	
	10			e Box 20	Print) 07. Baltimore 1	ND 21229	1	
	Sta Registr	20	31. Date filed (Month, Day, Year)  32. Registrar's 3	Signature	Sporked			

MASON, RICHARD

# Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. Amend Item#1, perME, 6838, 12/13/04 II

			1 - For Amer State Amer	nd item 19	State of Ma a per inf	ormant G8.	partment of Hi 38 12-15-0 Prtificate of L	ealth and IV Las Death	ientai Hygii Rei	ene 9. Mg. O. O. I	20251		
	Physici			e (First, Middle, Last Seph	Thoma	ıs	Morris		2. Date of Death Month DECEMBER	Day Year	7:54 P M		
	/Medic Examin			f not institution, give	street and number)		4b. City, Town, or BALTIMOI		,	4c. County of Dea			
	Funeral Director		5. Social Security N 579–42–18	1) 1) 10 de la marca dela marca dela marca de la marca dela marca de la marca de la marca de la marca de la marca	x 7. Age	e (In yrs. last birthda) 6 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1) 4-26-28	Year) 9. Bir	thplace (State or Foreign ountry)  Md.		
	ryland		Usual Residence of 10a. State	10b. County		10c. City, Town or I					10d. Inside City Limits		
	ith the Marylar or 28e-f show	Director	Md.	NA mber			Baltimore		100	g. Citizen of What Co	Y Yes 2 No		
	23e or	ai Di		dmondson A	Ave.		2122	3		USA			
920	s 1 and 2 should be filed within 72 hours after death with the Maryland Fleatht and Mental Hygiene. Item 27 Is marked other than "netural", or Items 23e or 28e-f show other treumetic event, the Medical Evertine rmust be rediffed at	l by Funerai	<ul><li>11. Marital Status</li><li>1 Never Marr</li><li>3 Widowed</li></ul>	ied 2 Married 4 Divorced	12. Was Decedent & Armed Forces? 1 Tyes 2 N M 1 Yes, Give Year or Dates:	Ever in U.S. 13	. Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2X No	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	te, etc.		
15-0	in 72 hc "netu	Completed		15. Decedent's Educify only highest grad	le completed)	(Giv	edent's Usual Occupa e kind of work done di DO NOT use retired)	tion uring most of worki	ing 16	6b. Kind of Business	/Industry		
212	ed with ygjene. ner thar t, the t	Comp	12th gra	ade	College (1-4or 5		tock Super	visor		GBMC			
and	d be filed ental Hygie ked other c event, II	o Be	17. Father's Name Unkn	(First, Middle, Last)				18. Mother's Name Frances	e (First, Middle, Ma		S		
Maryland 21215-0036	2 should I and Meni Is marker eumetic	<b>F</b> ()	19a. Informant's N	ame/Relationship (T)	ype, Print)					1	Zip Code)		
	1 and Health tem 27 other tr		Cynthia 20a. Method of Dis		Cousin	20b. Place of Disc	Dey Place,			08117 Oc. Location - City or	Town, State		
Baltimore,	Pages ment of H ent: If its ury or of		1 □ Burial 2 `4 □ Ponation	Cremation 3 DF 5 Dother (Specify)	Removal from State		ount Cem.	12-10					
Balt	permit. Pages 1 and 2 a Department of Health ar Importent: If item 27 Is any injury or other treu		21. Synuture of Fu	ineral Service Licens	Taltus J		Name and Address March F.H	*		imore, Md. E. North A			
	Physician /Medical Examiner		23 . fart1. Enter t shock, or hea ediate Cause this ase or condition (e) ulting in death)	(Final	a Heley	a consequence of):	nter the mode of dying	Va Scul	ar De	esease	Approximate Interval Between Onset and Death		
60, ×	ificate be executed g physician and as the burial-transit	I Examiner	Sequentially list co if any, feating to in cause. Enter Unde Cause (Disease or that initiated events resulting in death)	orlying injury		D. Kind of Business/Industry  GBMC  den Sumame)  Morris  ity or Town, State, Zip Code)  3117  D. Location - City or Town, State  altimore, Md.  more, Md. 21202  North Ave.  Approximate Interval Between Onset and Death  Selfs - Conset and Death  23d. Date of delivery Month Day Year  co use contribute to the cause of death?  2 \( \text{No} \) 3 \( \text{Probably} \) 4 \( Polynomy New New New New New New New New New New							
68760,	± 03 €	edical			d								
P.O. Box	Hospitel or Attending Physicien: The law requires that the death cert 44 hours after death. Funerel Director: After this certificate has been signed by the attendin tely filled in by the funeral director, page 2 should be detached for use.	by Physician/M	IF FEMALE: 23b. Was deceden in the past 12 1  Yes 2[ 9  Unknown	months?	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown				*				
ords, P	w requires that been signed t should be deta	ted by PI	Part II. Other signif	ficant conditions co	ntributing to death bu	ut not resulting in the	underlying cause give	n in Part I.		23e. Did tobacco use contribute to the cause of 1 Yes 2 No 3 Probably 4 7			
Vital Records,	Physicien: The law r this certificate has be al director, page 2 sh	Completed							24a. Was an autopsy pertorme 1 ☐ Yes 2	24b. Were au prior to death?			
f Vita	ysicien is certif director	To Be	25. Was case refer examiner?  Yes 2	red to medical	Hospital: 1 ☐ Inpatie	nt 2 🗓 ER/Outpatie	ent 3 DOA Other		n <i>(Check only one)</i> me 5 ☐ Residen	ce 6 □Other (Spe	cifv)		
o uo	tending Physicath.  tor: After this the funeral di		27. Manner of Deat 1 Natural	5 Pending	28a. Date of Injur (Month, Day	y Year) 28b. Time Injury	Work*	at :	28d. Describe how		,		
Division of	al or Attendi after death. I Director: A d in by the fu	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	investigation 6 Could not be determined	28e. Place of Injubulding, etc	ury - At home, farm, s c. (Specify)		'es 2 □No	28f. Location (Stre City or Town,	et and Number or Ru State)	ural Route Number,		
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical C	29a. Certifier (Check only one)	1□ Certifying Phy Medical Exam	rsician: To the best of iner: On the basis of and manner sta	examination and/or i	ath occurred at the time	inion, death occurr	and due to the cau ed at the time, date	se(s) and manner as e and place, and due	s stated. to the cause(s)		
	To the within 2 To the complet	Σ	29b. Signature and	title of certifier Ha	llaun	rd	29c. License O C			d. Date signed (Monte CEMBER 4,			
	Y		30. Name and addr	ess of person who o	ompleted cause of de	eath (Item 23a) (Type	n. Print) 111 PE	NN STREET	r, BALTIM	ORE, MARY	LAND 21201		
	Sta Registr		31. Date filed (Mon			ar's Signature	4 Span	EN					

		1 - For Stata Ragistrar	Sta	te of Ma	ryland /		artmen rtificate			and M	lental Hy	giene Rag. No.	004	39355			
Physic /Medi		1. Decedent's Name <i>(First, Midd)</i> Lillie				M	otley	,			2. Date of De Month	ath Day	Year	3. Time of Death			
Exami		4a. Fecility Name (If not institution Union Mem. Hos	, give street a spital	nd number)		4b. City, Town, or Location of Death Baltimore					<u> </u>	4c. C	ounty of Death NA				
Funeral Director		5. Social Security Number 219–38–5589	6. Sex 1 ☐ M 2		(In yrs. last b	irthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Dafe of Bird (Month, Da 6-29	y, Year)	9. Birth Con	nplace (State or Foreign untry) S.C.			
e Maryland a-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland NA			10c. City, Tov		cafion more					10d. Inside City Limits Y Yes 2 □ No					
th with th 23e or 26	al Dire	10e. Street and Number 4926 Lindsay	Rđ.				10f. Zip	Code 212	29			10g. Citize	n of Whaf Coi	untry?			
Naryland 21215-0036 2 should be filed within 72 hours after death with the Maryland is and Mental Hygiene. Is marked other than "natural; or Itema 23e or 28e-1 show raumatic event, the Medical Event and the rivillish at	by Funeral Director	11. Marital Status  1 Never Married 2 Mar.  3 XWidowed 4 Divorced	ied 1 🗀	Decedent E ed Forces? Yes 2 XN es, Give r or Dates:			Was Deced f Yes, spec		spanic Origin, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	1	Black, White	, etc.			
Maryland 21215-0036 d2 should be filed within 72 hours aff th and Mental Hygiene. Tris marked other than "natural", or Traumatic event, the Medical Exami	Completed	15. Deceden (Specify only highe Elementary/Secondary (0-12)	at grade compl	e <i>ted)</i> ege (1-4or 5+	-)	(Give life. L	lent's Usua kind of wor OO NOT us	k doné d e retired)	uring most		ng		of Business/I				
<u> </u>	Be Cor	8th grade 17. Father's Name (First, Middle,	Last)				Serv		18. Mothe	r's Name	(First, Middle,			City			
Irylai Should b nd Ment marked marice	To	Ernest 19a. Informant's Name/Relations	nio <i>(Tvoe. Prin</i>		Cherry		a Address	(Street a		llie		Mae					
alth alth	9	Frank Wilson	So	-		5602	. Key	Ave.	, Ba	ltim	ore, Md	. 21	215	p Code)			
Baltimore,		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S	from State		эгу, сгөп	sition (Nam natory or oth n Cem.	her place			3-04							
Baltimore permit. Pages 1 a Department of He Important: If item any injury or oth		21. Signature of Funeral Service		200	)		Name and	d Address	of Facility	1	Ba	ltimo	re, Md	. 21202			
Plysician Physician and Physician and the purial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last	b. <u>Ke</u>	spucuto le fo (or as a	consequence consequence	<b>s</b> ( of):								Onset and Death			
P.O. Box 68 that the death certifice ed by the attending pf detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	Ectopic pre Other (spe					23d. Date of delivery Month Day Year									
cords, P	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23e. Did to	V/		Date of delivery Month Day Year ontribute to the cause of death?			
The law The has b	e Completed											ned?	prior to co death?	Trown, State  Town, State  Md.  d. 21202  Ve.  Approximate Interval Between Onset and Death  () () () () () () () () () () () () () (			
on of ling Phys	Certification; To Bo	examiner?  1 ☐ Yes 2 No Hospital: 1 Inpatienf 2 ☐ ER/Outpatient 3 ☐								sing Hom 2	(Check only on the 5 Reside 8d. Describe ho 8f. Location (Si	ence 6 Downinjury of	courred				
DIVISIC To the Hospital or Attence within 24 hours after death To the Funeral Director: completely filled in by the 1	edical Cert	Check only 2 Medical	Physician: T	ouilding, etc.  o the best of he basis of e	my knowledge xamination an	e, death	occurred at	fhe time	, date and	place, a	City or Town	21150/5) 220	d manner as si	tated.			
To the within 2 To the complet	Med	29b. Signature and title of certifier	29c.	License r	number		2	9d. Date si	aned (Month.	Country?  Imerican Indian, //hite, etc.  Black  Indian State  Indian Sta							
10		30. Name and address of person of the Unio				(Type, P	rint) st Uni	versit	PAR	KWMY	Balte	more,	Marylan	x 2128			
Sta Registr		31. Date filed (Month, Day, Year)  DEC 1	3 2004	32. Registrar	s Signature	19	Sp	pork	21								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Edwin Earl Morgan Рм December 10, 2004 9:00 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2002 Oakland Rd. Middle River Baltimore If Under 1 Year | If Under 24 Hrs 5. Social Security Number 8. Date of Birth (Month, Day, Year) Jan. 29, 1920 **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours 12 M 2 □ F 248 42 0474 84 Director Yrs. South Carolina Usual Residence of Decedent the Maryland 10b. County items 23e or 28e-f show 10c. City, Town or Location 10d. Inside City Limits the Medical Examinational be notified at Director Maryland Baltimore 1 ☐ Yes 2X No Middle River 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 2002 Oakland Rd. 21220 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: WW II 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, be filed within 72 hours after 1 Never Married 2 Married ö Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: White 3 

Widowed 4 □ Divorced 'neturel', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Electrician n and Mental Hygie Commercial Electrician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Morgan Pages 1 and 2 should Sally Morgan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 is any injury or other treu once. Darlyn G. Morgan (Daughter) 2002 Oakland Rd. Baltimore, Md. 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 12/13/2004 Baltimore, Maryland 21. Signaure of Funeral Service Licensee 22. Name and Address of Facility Bruzdziński Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia 1 Week /Medical Due to (or as a consequence of): Examiner Acute Renal Failure 1 Week Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed End Stage Chronic Obstructive Pulmonary Disease burial-trans 1 Year Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy 4☐Pregnant at time of death Month 5 ☐ Other (specify) detached f Division of Vital Records, P.O. 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Dunknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2X No 1 Yes or Attending Physicien: Director: After this certification by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🖾 Residence 6 Other (Specify) 2 **X**No Certification; To 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 2 Accident investigation 1 Tes 2 No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours a To the Funeral I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 54749 December 11, 2004 30. Name and address of person who completed cares of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

Allen Reilly M.D.

31. Date filed /Mo

32. Registrar's Signature

4805 Benson Avenue Baltimore, Md. 21227

			For State Registrar	State o	f Maryla	and / Depa	artment of F	lealth a Death	and Mental	Hygier	/	39357		
	Physici		1. Decedent's Name (First, Middle, L Gordon Wesley M						2. Date of Month Decei		200 <sup>4</sup> gar	3. Time of Death 11:55 a <sub>M</sub>		
	/Medic Examir		4a. Facility Name (If not institution, g	ve street and nur		iter	4b. City, Town, o		of Death		4c. County of Death Harford			
	Funeral Director		5. Social Security Number 215-28-4366 6.			rrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours		of Birth	9. Bint Man	nplace (State or Foreign Light) and		
	Maryland f show	lor	Usual Residence of Decedent  10a. State 10b. County  Md. Harfor	·d	10c.	City, Town or Lo Be 1	ocation Air					10d. Inside City Limits 1 ☐ Yes 2 ☐ No		
	with the I	i Director	10e. Street and Number  1939 Millington	Sauare			10f. Zip Code 210	)15		10g. (	10g. Citizen of What Country? U.S.A.			
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any righty or other traumatic avant. Ite Medical Example profiled at Once.	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Dece Armed Fo 1 ☐ Yes If Yes, Giv Year or Da	rces? 2√∑No e		Was Decedent of H If Yes, specify Cuba			or No-	14. Race - Amer Black, White Specify: Wh	, etc.		
21215-0036	d within 72 ho giene. Ir then "natur. I're Medical I	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12 years  16a. Decedent's Usual Occupation (Give kind of work done during most of work forms during most of work fife. DO NOT use retired)  supervisor								Kind of Business/Industry  ip building			
Maryland	uld be file Aental Hy rkad othe tic avant,	To Be (	17. Father's Name (First, Middle, Las John E. Mitche						er's Name <i>(First, Mi</i> a Gertrud					
Mary	nd 2 shoil alth and N 27 Is ma		19a. Informant's Name/Relationship  Ibolya Mitchell						or Town, State, Z., Md. 210	•				
Baltimore,	Pages 1 ar nent of Heal int: If itam 2 iry or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Spec		State	-	sition (Name of matory or other place Crematory	· .	Date 12/13/200	20c. Location - City or Town, State  004 Baltimore, Md.				
21. Signature of Funeral Service Licensee  22. Name and Address of Facility Schimunek Funeral 610 W. MacPhail Ro														
8760, 4	Interest of executed // Medical Examiner and street on the purial-transit	dical Examiner	23a. Part1. Enter the disease, or coshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (	or as a cons	eath. Do not enter that each sequence of):	er the mode of dyin	g, such as	cardiac or respirato	ory arrest,		Approximate Interval Between Onset and Death  4 Months		
O. Box 68	aath certif attending for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		_	23d. Date of delin Month	very Day Year							
α.	luires that the de n signed by the ild be detached	by	Part II. Other significant conditions	contributing to de	eath but not	resulting in the u	nderlying cause give	en in Part I.				the cause of death?		
al Recol	: The law requir cate has been si , page 2 should I	Completed								Was an autopsy performed? es 2 □ N	prior to co	opsy findings available ompletion of cause of		
Division of Vital Records,	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification: To Be	25. Was case referred to medical examiner?  1 Yes No  27. Manner of Death  1 Natural 5 Pending investigati 2 Accident 6 Could not determine	28a. Date of (Mont)	of Injury h, Day Year		28c. Injun Work	er: 4 □ Nui y at	28d. Desci	Residence ribe how in	6 ☐ Other (Specially occurred			
<u>S</u>	spital or A ours after neral Dirac filled in by		4   Homicide	Duildi	best of my		n occurred at the tim	ne. date and		r Town, Sta		stated.		
	To the Hospita within 24 hours To the Funeral completely filled	Medical			asis of exam		vestigation, in my o	pinion, deat		ime, date a		to the cause(s)		
	F 3 F 8		· Bar		a of decide "	Itom (22-) /* -	D5	484	/	12/	2/9/04			
	5		30. Name and address of person who ASHKAN B  31. Date filed (Month, Day, Year)	AHERAN	12 /	62 S	Atwood	Rd	Derit 2	00	Bol Air V	14		
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DHMH 17 Rev 1/2001

#016584

Mitchell, Gordon

ORIGINAL

			For State Registrar		of Marylar		artmen rtificate					Reg. No	00	14.	30	250
- 18	Physici	an	1. Decedent's Name (First, Middle, Coral R. Morela								2. Date of De Month	Da	y 000	ear	3. time 1	othern ()
	/Medic	al	4a. Facility Name (If not institution,		mber)		4b. City.	Town, or	Location of	of Death	Decemb		. County of		9:24	7 A "
	Examin	er	19 Melken Cour		Baltimore						Baltimore					
	Funeral		5. Social Security Number 6	Sex	Month					nder 1 Year If Under 24 Hrs. 8				9. Birthpl	ace (State	or Foreign
	Director		212-56-7767	1□ M 2□XF	54	Yrs.					March	5,19	5,1950 Maryland			
	land		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10	Od. Inside (	City Limits
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23s or 28s-f show aumatic event, Ite Medical France or Instituted at	ţ	Maryland Baltim	ore			Bal	timo	re						1 ☐ Ye	s 2∭No
	th the	Directo	10e. Street and Number				10f. Zip	Code				10g. Cit	tizen of Wh	at Coun	try?	
	23£		19 Melken Cour						1236					S.A.		
	er deg	Funeral	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13.	Was Deced If Yes, spec	ent of His ify Cubar	spanic Ori n, Mexican	gin? (Spe 1, Puerto	ecify Yes or No Rican, etc.)	0-	14. Race - Black,	Mhite, e		
36	rs aft	by F	1 ☐ Never Married 2 🛣 Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed For 1 Test 1 Yes, Gir Year or D	≥ LAINO ve )ates:		1 ☐ Yes 2	No.	Specify:				Specify:	W	hite	
9-0	2 hou		15. Decedent's	Education		16a. Dece	dent's Usua	l Occupa	tion	e né worki		16b. K	ind of Busi	ness/Ind	ustry	
218	thin 7	Completed	(Specify only highest Elementary/Secondary (0-12)	College (	1-4or 5+)		kind of wor DO NOT us		uring mosi	t OF WORK	rig		.,			
2	lygien her th	S	12th Grade	not)		Hom	emake	l	19 Motho	r'o Namo	(Eirat Middle		un Ho			
Baltimore, Maryland 21215-0036	to be of	Be c	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden S  Joseph Bowman  Jacqueline Lette										,			
چ	should nd Me mark imatic	ျ	19a. Informant's Name/Relationshi			19b. Mailii	ng Address	(Street a		<u> </u>	al Route Numb			ate, Zip	Code)	
ž.	1 and 2 Health a iem 27 is		Michael Drasal	(8)	on)	390	4 Huni	t Ha	rbor	Road	, Balt	imor	e, MD	212	20	
o e	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic 2008.		20a. Method of Disposition 1 ☐ Burial 2 🂢 Cremation 3	□ Removal from		Place of Dispo cemetery, crea	sition (Nam natory or of	e of her place	9)	С	Date	20c. L	ocation - C	ity or Tov	wn, State	
Ě	Pages tment of I tant: If its jury or o		`4 □Donation 5 □ Other (Spe	cify)	7 Ba	yview (	Crema	tory	1	2/13	/2004	Bal	timor	e, M	arylo	ınd
Bal	permit. Departm Imports any inju		21. Signature of Fundral Service Ci	censee	~						munek 1 ltimore					
	*	i	23a. P-f11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Decomposition of the control of the												ate etween	
	Physician	l)	Immediate Cause (Final disease or condition	a	Myo	rard	hal	•	20-L	ar	etion	)			I el	Death
	/Medical Examiner		resulting in death)	Due to	(or as a consec	juence of):	1.			1	1.4.				110	+
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	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			hom	, _	Ri	ho	C T-	ailu	1			104	22A
0,	ate be executed hysician and the burial-transi	Еха	resulting in death) Last	Due to	(or as a conseq	uence of):		*								
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9 ×	eath certific attending p	/Me	IF FEMALE:	23c. If ves. ou	tcome of pregna	ancv							23d. Date	of deliver		
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ta	sicien: Th certificate irector, pag	Be C	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o					
>	Physic this ce al direc	10	1 ☐ Yes 2 No			ER/Outpatier			4 🗆 140		ne 5 Resi				1	
o u	ding Ph h. After th funeral	ion:	27. Manner of Death 1 ☐ Hatural 5 ☐ Pending		of Injury th, Day Year)	28b. Time of Injury	M 28	Sc. Injury Work	at ? ′es 2 ⊡ ľ		28d. Describe	how injur	y occurred			
isio	death. ctor: A y the fu	ertification;	2 Accident investiga 3 Suicide 6 Could no		of Injury - At h	ome, farm, str			65 2 1		28f. Location (	Street an	nd Number	or Rural	Route Nur	nber,
Div	s after s after al Dire	Certi	4  Homicide	build	ing, etc." <i>(Specit</i>	(y)					City or To	wn, State	)			
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	edical (		Physicien: To the aminer: On the b and man												s)
	To the within To the comp	M	29b. Signature and title of certifier	st r	). 0.		29c.	License	number		13	29d. Dat	te signed (	Month, D	ay, Year)	
	12		30. Name and address of person w	no completed caus	se of death (Iter	n 23a) (Type,	Print)	. (	1 00	, )			0 1		1	/
			JL JUhn  31. Date filed (Month, Day, Year)	Loh	112 4	ma		thu.	2 . 6	Sa	Himon	re	ni	02	_(22	- )
B	Sta Registr	*	DEC 1 3 2004		war )	6 1	park	2/								

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Daniel Mayer December /Medical 2004 8:00 PM<sup>M</sup> 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) unk **Funeral** 8. Date of Birth (Month, Day, Year) 1MM 2□ F 228-42-4209 unk Director 67 Jan 1, 1937 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23a or 28e-f show any injury or other treumatic event, the Modical Examiner must be notified at once. 10d. Inside City Limits MD Prince George's Director Hyattsville 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6500 Riggs Road 20783 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No UII If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2) No ģ Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Sumame) unk 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Washington Adventist Hospital 7600 Carroll Avenue Takoma Park, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State `4 □Donation 5 🖔 Other (Specify) in state 21. Sign was or Funeral Service Sicensee Nonald State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or feart failure. List only one cause on each line. Approximate Interval Between Onset and Death Renal Immediate Cause (Final **Physician** Carrinoma will metestess disease or condition resulting in death) Man /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an the funeral director, page 2 autopsy performed? res 2 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Certification: To 1 ☐ Yes 2 ☑ No 1- Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending after death. Director: Af investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 0 29d. Date signed (Month, Day, Year) D45660 of person who completed cause of death (It addres m 23a) (Type, Print) BOLJE 124 CALLAN ७६, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 3 2004

State of Maryland / Department of Health and Mental Hygiene () 39360 For State Registral Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year Ness , SR. 4:12 PM **Physician** 115WORTH VACOB Oe C 2004 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Westminster CARROLL HOSPITAL CARROLL CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Sociat Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 15 M 2 F 217 28 7067 Director MARYLAND Usuat Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28a-f show other traumatic event, the Medical Examenar must be notified at 1 Yes 2 No MD -INKS BURG Directo CARROLL 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 8 USA Bluo 2104 Baltimone "natural", or items 23a Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or itam any injury or other trainmetr. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Š Whit Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Citywide Management Elementary/Secondary (0-12) College (1-4or 5+) Supervisor MAINTENANCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Hilda G. Bollinger Joseph E. Ness ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore Blue Lot 79 FINKSBURG MO 21048 L. Ness, PRISCILLA WIFC 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 □ Cremation 3 □ Removal from State 12/13/2004 Meanow Branch Cen Westminster MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility JN ZUM BRWN FITE MCN CO. Part 1. Inter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Elbertsburg my Approximate Interval Between Onset and Death Immediate Cause (Final m185/44 **Physician** resulting in death) /Medical Due to (or as a consequence of): **Examiner** Smar Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequ Examiner The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. the attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 I Inknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performe 1 ☐ Yes 2 No or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 2 1 🗌 Yes 1 Inpatient 3 DOA After this 27. Mann of Death funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lonathan 32. Registrar's Signature 31. Date fited (Month, Day, Year) State Aparti. Registrar

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Unknown 04-397		Please Type or P		ndelible Ink. Ensure			
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DOS	Registrar  1. Decedent's Name (F	First, Middle, Last)		erinicale of Death	2. Date of Death		3. Time of Death
Physician /Medical	TARI	K AUBRE	TY N	ELSON	December 1	r 5, 2004	0957 a <sup>м</sup>
Examiner	4a. Fecility Name (If no 1600 Bloc	t institution, give street and numb k of Edmondson	Avenue	4b. City, Town, or Location of De Baltimore	eath	4c. County of Deat	4
Funeral Director	5220 88 340	6. Sex 102 M 2 F	Age (In yrs. last birthda	Months Days Hours M	fin. 8. Date of Birth (Month, Day,	9. Birtl 1977 M	nplace (State or Foreign unity) ARYLAND
and	Usual Residence of De 10a. State 10	ocedent ' Ob. County	10c. City, Town or	Location			10d. Inside City Limits
Mary!	MD	NA	BAL	TIMORE	CZTY		1  Yes 2 No
ind 21215-0036  filed within 72 hours after death with the Maryland tal Hygiene.  d other than "natural", or items 23a or 28a-f show event, the Medical Evantinar must be indiffed at Be Completed by Funeral Director	10e. Street and Number	W. FAYET	TE ST.	10f. Zip Code 2/22	3	g. Citizen of What Co	untry?
filer death	11. Marital Status 1 D Never Married	12. Was Decede Armed Force 1 Yes 2	ent Ever in U.S. 1: es?	3. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No- uerto Rican, etc.)	14. Race - Ame Black, White	
Maryland 21215-0036 Id 2 should be filed within 72 hours all Illh and Marial Hygiens Z7 is marked other than "natural; or traumatic event, the Madical Exam To Be Completed by F	3 ☐ Widowed 4 [	Divorced If Yes, Give Year or Date	16a De	1 ☐ Yes 2 ☑ No Specify:		Specify: 6b. Kind of Business/	Industry
ges 1 and 2 should be filed within 72 hou to Health and Manial Hygiene. If I che marked other traumatic event, the Medical To Be Completed	(Specify	only highest grade completed)	or 5+)	ve kind of work done during most of a DO NOT use retired)	working	SITAM	TIVE
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Mary 12 sho 1 and 1		e/Relationship (Type, Print)	19b. Ma	tiling Address (Street and Number or	11 01	City or Town, State, Z	(ip Code)
re, N s 1 and Health Item 27	20a. Method of Dispos		cemetery c	position (Name of rematory or other place)	Date 2	Oc. Location - City or	Town, State
Page nent o	1 Ø Burial 2 □ C	Cremation 3 ☐ Removal from Sta ☐ Other (Specify)	KING	MEM. PK. 13	2-11-04 1	RANDAUS	TOWN, MD
Baltimore, M permit. Pages 1 and 1 Department of Health Important: if titem 27 amy injury or other tr once.	21. Signature a Fune	ral Service Licensee	Swan	22. Name and Address of Facility	HÖWETL P HEHTS, 1.	EUNERAC BACTO, N	HOME ND 21207
	23a. Part. Enter the	disease, or complications that cau ailure. List only one cause on eac	sed the seath. Do not on h line.	enter the mode of dying, such as care	diac or respiratory arres	st,	Approximate Interval Between Onset and Death
Physician /Medical	Immediate Cause (Fir disease or condition resulting in death)	a. QUAS	hot wand	ds (a) of he	2d		
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executed or and ial-transit Examiner	Sequentially list condi if any, leading to imme cause. Enter Underlyi Cause (Disease or inju	ediate Due to (or ing	as a consequence of):				
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ox 6 certific nding puse as	IF FEMALE: 23b. Was decedent pr	regnant 23c. If yes, outco				23d. Date of deli	
Division of Vital Records, P.O. Box 6876.  To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicial completely tilled in by the funeral director, page 2 should be detached for use as the but Medical Certification: To Be Completed by Physician/Medical	in the past 12 mo 1 ☐ Yes 2 ☐ N 9 ☐ Unknown	onths?	nt at time of death	3 □Ectopic pregnancy 5 □ Other (specify)		Month	Day Year
IS, P. ires that signed by the details by P. ires		ant conditions contributing to dea	th but not resulting in the	underlying cause given in Part I.		acco use contribute to	the cause of death?
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The lav		,			autopsy perform  1X Yes 2	ed? death? □ No 1 2 Yes	
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g Physi g Physi er this o eral dir.		28a. Date of	Injury 28b. Time	of C	g Home 5 ☐ Resider 28d. Describe how		1 Scene
ending ending sath. or: Afte he fun	1 Natural 2 Accident	investigation 12-	5-04 09:	57 M 1 □ Yes 2 No	Subj	sct 2No	57
Division ce tall or Attending Person and Director: After death.  al Director: After ded in by the funers Certification:	3 ☐ Suicide 4 Homicide	determined 28e. Place of building	f Injury - At home, farm, , etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	State) E	nond Son Are
Division of Vital Re To the Hospital or Attending Physician: The J Within 24 hours after death. To the Funeral Director: After this certificate ha completely tilled in by the funeral director, page Medical Certification: To Be Com	29a. Certifier 1[ (Check only 2)	☐ Certifying Physician: To the bas ☐ Medical Examiner: On the bas	is of examination and/or	eath occurred at the time, date and pl investigation, in my opinion, death o	ace, and due to the car	use(s) and manner as te and place, and due	stated. to the cause(s)
To the within 2 To the comple	29b. Signatore and titl		O O	29c. License number		d. Date signed (Month	
	30 Name and address	s of person who completed cause	of death (Item 23a) (Typ	OCME  oe, Print) 111 P		ecember 6,	
State	PATE C.  31. Date filed (Month,	A Aronica-t	JIAK ME	111 Penn Str	eet, Baltir	more, MD 2	1201
Registrar	DE	21 3 2004	ina G	Loods			

ORIGINAL

			State of Maryland / D	Department of Health and Mental Hygiene  Certificate of Death  Reg. No. 004 39362	2
			Decedent's Name (First, Middle, Last)	2. Date of Death 3. Time of Death	h
	Physicia		Doris Elizabeth Neubauer	December 6, 2004 12:15 P	М
	/Medic Examin		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death  4c. County of Death	_
	Examin.		3416 Dudley Avenue	Baltimore N/A	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth		ign
	Director		215-10-4602 1 M 2K) F 88	June 28, 1916 Maryland	
	D .		Usual Residence of Decedent		
	aryla ehov	_	10a. State 10b. County 10c. City, Town	A My - a -	
	Ba-f	cto	Maryland N/A	buccinore	-
	vith th	Director	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?	
	death with the Maryland rme 23a or 28a-f ehow r runt tee nullited at	Funeral	3416 Dudley Avenue	21213 U. S. A.	
	ltern ner d	Š.	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 ▼ No	13. Was Decedent of Hispanic Origin? (Specify Yes or No- lf Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.	
5	ours after death with the Marylar rai', or Heme 23e or 28a-1 e how Examiner must be nutified at	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 1 No If Yes, Give 3 1 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 ♥ No Specify: Specify: White	
0500-c	72 hours "natural", adical Exa	pe	15. Decedent's Education 16a. I	Decedent's Usual Occupation 16b Kind of Business/Industry	
2	nin 7.	ple	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of working life. DO NOT use retired)	
7	filed within 72 hours after Hygiene. ther then "natural", or lte the Medical Examine	No.	8th Grade	Homemaker Own Home	
land	be file ital Hy id oth event	Be Completed	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)	
<u>a</u>	should b nd Ment marked	Tol	William Sullivan	Jane Manning	
a.	2 sho and ls mu			Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
e, ≤	s 1 and if Health item 27 other tr			416 Dudley Avenue, Baltimore, Maryland 21213	
o e	ges 1 it of H if itel		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	Disposition (Name of v, crematory or other place)  Date 20c. Location - City or Town, State	
Баптітог	nit. Pages artment of ortant: If it injury or o			s of Faith   12/10/2004   Baltimore, Maryland	<u>l_</u>
ža	permit. Depart Import any in		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Schimunek Funeral Homes	
	20239		Defame Kerrike	3331 Brehms Lane, Baltimore, Maryland 21213	
	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	ot enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between Onset and Death	
	/Medical		resulting in death)  Due to (or as a consequence of	n:	_
	Examiner	1	Sequentially list conditions b.		
	D #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	4):	
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280	9 % 9	_	d		_
	The law requires that the death certificat tie has been signed by the attending phy tage 2 should be detached for use as th	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery	
ROX	atter 1 for u	clar	23b. Was decedent pregnant in the past 12 months?  1 Uve birth 2 Fetel death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Month Day Year	
j.	the d y the iched	lsku	1 U Yes 2 Doo 9 Unknown		
ت. ح	res that the de signed by the a be detached f	by PI	Part II. Other significent conditions contributing to death but not resulting in	the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?	
Sp	w require been sig should b		hypeviension	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknow	wn
Hecord	s bee	Completed	DAN DHEVAL VASILLA	24a. Was an autopsy findings availa prior to completion of cause or	.ble
	The law	mo	Hyman I Di dani A.	performed? death?	Of.
Vitai	ician: Th certificate rector, pag	4	25. Was case referred to medical	1 ☐ Yes 2 ☐ No   1 ☐ Yes 2 ☐ No   26. Place of Death (Check only one)	
	A w D	To B	examiner?  1   Yes 2   No   Hospital: 1   Inpatient 2   ER/Out	Other	
וס ר	ig Ph ter th		27. Manner of Death 28a. Date of Injury 28b. Ti		
0	andir ath. or: Af	atlc	2 Accident investigation	M 1 Yes 2 No	
DIVISION	r Att	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, lard building, etc. (Specify)	m, street, lactory, office  281. Location (Street and Number or Rural Route Number, City or Town, State)	
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	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	edical	(Check only 2 Medicel Examiner: On the basis of examination and	death occurred at the time, date and place, and due to the cause(s) and manner as stated.  You investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	
	thin 2 the mplel	Med	one) and manner stated.  29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)	
	£ ₹£ 8		I Washi & Day DIC	) DESIGN DORANTED & 2011	J
	11		30[ Name and address of person who completed cause of death (Item 23a) (1	Types Prints	T
	10		HIAN Dan m-D- () + Time	Ividat Road BAltimore mary land	2
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			1 - For State Registrar	State of Mai	•	ertificate of Deal		Reg. NK	1001	39363
			Decedent's Name (First, Middle, Last)	0	-	7	2. Date of Month			3. Time of Death
	Physici /Medio		JOSEBA LE	FRAY FR	10 20E	/	Dean		7 200	4 05:46 PM
	Examin		4a. Facility Name (If not institution, give	4 4 70 4 1		4b. City, Town, or Location	n 1	40	County of Deal	th ?
			5. Social Security Number 6. Sec		In yrs. last birthday	Baltimo	der 24 Hrs. 8. Date of	Birth	Q Birt	hplace (State or Foreign
	Funeral Director			M 2□F	Yrs. iasi birtiida) Yrs.	Months Days Hou		Day Year		ountry)
			Usual Residence of Decedent				1.77.7			· Syn Sir Jog
	Marylan f show	for	10a. State 10b. County	A	Oc. City, Town or I	+1more	city			10d. Inside City Limits 1 1 Pres 2 □ No
	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Heath and Mental Pygiene. ortent: If item 27 is marked other than "neturel; or items 23e or 28e-f show injury or other traumetic event, the Medical Exertical initial to notified at injury or other traumetic.	Funeral Director	10e. Street and Number	11.10	1	10f. Zip Code	* (	10g. Ci	tizen of What Co	ountry?
	ms 23	eral	11. Marital Status	12. Was Decedent Ev	# 1/E//1. er in U.S. 13	Was Decedent of Hispanic If Yes, specify Cuban, Mex	Origin? (Specify Yes or	No-	14. Race - Ame	
92	or ite	/ Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No If Yes, Give	·	1 Yes 2 No Spec			Black, Whit	6, etc.
21215-0036	hours turel',	ed by	3	Year or Dates:	16a Dec	edent's Usual Occupation		16b K	(ind of Business	Industry
15	nin 72 n "nel	Completed	(Specify only highest grad	cation e completed) College (1-4or 5+)	(Giv	e kind of work done during r DO NOT use retired)	most of working	)	t .	11 61 6
212	filed with Hygiene. ther than	mo:	Elementary/Secondary (0-12)	College (1-401 5+)	110	USEKEE	PER	(A	nIV,	HOSPITAL.
	be filed ntal Hygid of other event, t	Be	17. Father's Name (First, Middle, Last)	On 1		18. M	other's Name (First, Mid	ldle, Maider	Sumame	0
Maryland	2 should be and Mental is marked o	은	ETHANIEL	5KI d	GE 1	ling Address (Street and Nu.	mbor or Pural Pouto Nu	Thor City	or town State	() (J) /(J
Mai	id 2 st ith and 27 is r traur		19a. Informant's Name/Relationship (Ty	THER ET	190. IMal	GOFFAX /	ANDING	14	BAH	md 21207
ē,	s 1 and f Health item 27 other tr		20a. Method of Disposition	DOC LA	20b. Place of Disp	position (Name of ematory or other place)	Date	20c. L	ocation - City or	Town, State
E O	Pages nent of l nnt: If its iry or o		1 Paurial 2 □ Cremation 3 □ F  3 4 □ Donation 5 □ Other (Specify)	lemoval from State	ARbutu	5 MEMPK	12/14/200	1/1	Rbutu	is Ind
Baltimore,	permit. Pag Department Importent: I any injury o		21. Signative of Funeral Service Licens	ee 🖊		22 Name and Audress of Fa	W. JonES	JR	. I-un	. SVCPA
	Dep imp any any		plane as	amen	gres !	1814 N. BR	COAdWAY	BA	1.70. m	Approximate
ı			23a. Part1. Enter the disease, or complesshock, or heart failure. List only or	ne cause on each line	e death. Do not e	nter the mode of dying, such	as cardiac or respirato	y arrest,		Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		consequence of):	1 Emboly	.5	-		10-30 min
п	Examiner		_ f		sonsoquones orj.					
	₽ ≅	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):		-,			
	and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to for as a	consequence of):					de annie de la companya de la compan
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687	a % a		_							
Вох	eath certific attending p I for use as t	M/u	23b. was decedent pregnant	3c. If yes, outcome of 1 ☐ Live birth 2		☐Ectopic pregnancy			23d. Date of de	
	The law requires that the death certifica tte has been signed by the attending phoage 2 should be defached for use as it	Physician/Med	in the past 12 months? 1 □ Yes 2 ☑ No	4☐Pregnant at tir		Other (specify)		-	Month	Day Year
P.0	that the de ted by the a detached t	Phy	9 ☐ Unknown  Part II. Dther significant conditions co	ntributing to death but	not resulting in the	underlying cause given in Pr	art I. 23e. D	id tobacco	use contribute to	the cause of death?
ds,	w requires to been signer should be considered.	d by	Chronic Rena	I hank	icina	and an arrangement of the second of the seco			□No 3□Pr	
Records,	w requ	Completed	Congestive He	ext fai	here		24a. V	÷ Vasan	24b. Were au	itopsy findings available
Re	The lav	omp	Dishetes Wei	Thus	Hubert.	un Ci'ann	157	utopsy erformed? os 2□ No	death?	completion of cause of
Vital		BeC	25. Was case referred to medical examiner?	2143	1 0 00	26. P	lace of Death (Check or			
of V	90 (7)	70	1 Tes 2 No		2 ER/Outpati		Nursing Home 5 F			cify)
on c		lon:	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day )	(ear) 28b. Time Injury			be now inju	ry occurred	
Division	I or Attendi after death. Director: A I in by the fu	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury	r - At home, farm, s		28f. Location			ural Route Number,
Οį	al or A	Certification:	4  Homicide	building, etc.	(Specify)		City of	Town, State	9)	
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of ner: On the basis of e and manner state	xamination and/or	ath occurred at the lime, date investigation, in my opinion,	e and place, and due to death occurred at the ti	the cause(s ne, date an	and manner as d place, and due	s stated. to the cause(s)
	o the ithin 2 o the omple	Med	29b. Signature and title of certifier	and manner state	u.	29c. License numb	per	29d. Da	ite signed (Mont	h, Day, Year)
	F 3 F ŏ		Bin Mather	, MBRS	S	RES -	000	Dec	embuc	7, 2004
	$\cap$		30. Name and address of person who co	ompleted cause of dea		. 1 1 . 0 0	14.5			,
	1		BINU MATHE	W Sin	1	pital of 18	altimore			
	Sta Registi		31. Date filed (Month, Day, Year) DEC 1 0 2004	32. Registrar	s signature	48				
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DHMH 17 Rev 1/2001

" Patient tenoun as Joseph Pridget"

ORIGINAL

The state of the s	3. Time of Death  11:29 P
S. Social Security Number   6. Sex   7. Age (in yrs. last birinday)   If Under 1 Year   If Under 24 Hrs.   8. Date of Birth   9. Birth   Coul   10. City. Town or Location   10. City. Town or	
10a. State   10b. County   10c. City, Town or Location   10b. City Town, Minded   10b. City City Town, Minded   10b. City City Town, Minded   10b. City City City City City City City City	ímore place (State or Foreig intry) Maryland
17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Maiden Surname)	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Maiden Surname)	can Indian, , etc.
Solution of Participal of the state of Disposition   180 minus of Commence of State of Disposition   180 minus of Commence of Commence of State of Disposition   180 minus of Commence o	ndustry Printing
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,    Immediate Cause (Final disease or condition	
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Physician disease or condition  [Medical Physician as cardiac or respiratory arrest, as cardiac or re	own, State Maryland
Immediate Cause (Final disease or condition a. Colon Concur resulting in death)	
Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	Onset and Death
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 23d. Date of deliver	ory Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the underlying cause given in Part I.	i c
	osy findings available npletion of cause of 2 \(\sum \text{No}\)
S TO TO THE STATE OF THE STATE	71007
1	
and manner stated.  29b. Signature and fittle of certifier  D S 3 3  December  29c. License number  D S 3 3	Day, Year)
30. Name - d address of person who completed cause of death (Item 23a) (Type, Print)  State Registrar  31. Date filed (Month, Day, Year)  32. Registrar's Signature  ADDREAD  30. Name - d address of person who completed cause of death (Item 23a) (Type, Print)  6601 N. Cha	ırles Stree

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year December 9 2004 4:50a. /Medical Rana 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner <u>Genesis Elder Care Caton Manor</u> Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05 26 45 **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) India Days 1 M X F Yrs. 59 Director 213-35-2334 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23e or 28e-f show any rigury or other treumatic event, the Medical Exercises must be multified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ¥Yes 2 □ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1712 West Lombard Street 21223 U.S.A.

14. Race - American Indian,
Black, White, etc. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: Completed by 3 ☑ Widowed 4 ☐ Divorced Specify: Asian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10th grade Unemployed Unemployed na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Unknown Abdul Haque 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jalaluddin Akbar-Bro-In-Law 274 5th Ave S.W. Glen Burnie, Md 21061 Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) King Memorial Park 12/9/04 Randallstown, Md 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F/H West ala arch 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cirrhan **Physician** dha /Medical Due to (or as a consequence of): Examiner Esophage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed ending physician and use as the burial-transit morente Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 1 No 1 ☐ Yes 2 ☐ No 1 Yes Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Ho 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending after death. 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel of within 24 hours at To the Funerel D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 31464 MD 12/9/04 WAZI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Entono A HASIZMI MD. St Snite 308 Balt. MD 2/201 821N. 31. Date filed (Month, Day, Year) 32. Registrar's Signature; Registrar 3 2004

			T- State of Maryland / Registrer		artment of Health and rtificate of Death		711111/1 30368
Ė			Decedent's Name (First, Middle, Last)			Reg. 1	3. Time of Death
	Physici		Jacob Lambert Ringsdorf			_	10, 2004 7:19 pm <sup>M</sup>
	/Medic Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Deat	T	4c. County of Death
			239 South Eastern Court		Essex	P	Baltimore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last b		If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9 Rirthplace (State or Foreign
	Director		216-28-3065 73	Yrs.	Market Bays	11/17/193	
	MC T		Usuel Residence of Decedent  10a. State 10b. County 10c. City, To	wn or Lo	cation		10d. Inside City Limits
	Mary -1 sh	ξ					1 ☐ Yes 2 ☐ <b>Y</b> fo
	r 28a	Director	Maryland Baltimore Essex  10e. Street and Number	X.	10f. Zip Code	10g. (	Citizen of What Country?
	h with	DIE	239 South Eastern Court		21221		C 3
	deel	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	13.	Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - American Indian,
9	after or ite	/Fu	1 □ Never Married 2 ( Married   1 □ X = 2 □ No 1957   1 □ X = 3 □ No 1957   1 □ No 1957	- 1	f Yes, specify Cuban, Mexican, Puerl I □ Yes 2 XNo <i>Specify:</i>	o Hican, etc.)	Black, White, etc.
21215-0036	72 hours after deeth with the Marylend natural', or items 23a or 28a-f show dical Examiner must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1959		TE 165 2EMMO Specily.		Specify: White
5	"net	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	lent's Usual Occupation kind of work done during most of wor DO NOT use retired)	king 16b.	Kind of Business/Industry
7	with! lene. then	Junc	Elementary/Secondary (0-12) College (1-4or 5+) 12	rive:		3	
	filed Hygi other		17. Father's Name (First, Middle, Last)	_Tve.		all Ar. ne (First, Middle, Maid	Mored Car
Maryland	lid be lental kad ic ev	To Be	Joseph Lambert Ringsdorf			Czarnow	
ary	and N	_		b. Mailir	g Address (Street and Number or Ru		
	and 2 relth a		Frances Anne Ringsdorf (Wife)	239	South Eastern Cou	rt Essex	Maryland 21221
ore	of He of He fiten		20a. Method of Disposition 20b. Place	of Dispo	sition (Name of		Location - City or Town, State
altimore,	Pag ment ant: i		'4 Donation 5 Other (Specify) Mary	land	Veteran Cem. 20	Section 1	rison Forest, MD
Bait	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylen Depertment of Heelth and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	22 B1	. Name and Address of Facility CUZdZinski Funera		
	<u>0</u> .0 ⊆ 6 0	1	Michael C. Toffier, Sr.	14	407 Old Eastern A	venue Esse	ex, Maryland 21221
			23a. Part1. Enter the disease, or conducations that caused the death. Do shock, or heart failure. List only one cause on each line.	not ente	er the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
	Prysician	9 1	Immediate Cause (Final disease or condition resulting in death)	F	1BEDS15 1010P	ATHIC	Onset and Death
	/Medical Examiner		Due to (or as a consequence	of):	//		
	110	Į.	Sequentially list conditions, and any, leading to immediate b.	oft.			
	uted d ansit	Examiner	if arry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	, .			
o.	exec en en rial-tr	Exa	resulting in death) Last  Due to (or as a consequence	of):			
68760,	icate be executed physicien end s the burial-transit	edicai	d				
_			IF FEMALE:				
Вох	eath certiff ettending I for use as	lan/	23b. Was decedent pregnant in the past 12 months? 1☐ Live birth 2☐ Fetal death	h 3	Ectopic pregnancy		23d. Date of delivery  Month Day Year
P.O.	the e	Physician/M	1  Yes 2 No 4 Pregnant at time of death 9 Unknown 9 Unknown	5 🗆	Other (specify)		Month Day Year
<u>.</u>	The law requires that the death certifule has been signed by the ettending rage 2 should be detached for use a	Ph	Part II. Other significant conditions contributing to death but not resulting	in the un	deriving cause given in Part I	23e Did tobacco	o use contribute to the cause of death?
Vital Records,	uires sign ld be	d by	PULMONARY HYPERTENSION		y and a great with account	1 ☐ Yes	5 W
Ö	w requir been si should	lete				24a. Was an	
Ř	he lav e has age 2	Completed				autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
ta		0	25. Was case referred to medical		26 Place of Doc	1 ☐ Yes 2 2 1 N th (Check only one)	lo 1 Yes 2 No
	Physici this cer al direct	0	examiner? 1 ☐ Yes X☐ No Hospital: 1 ☐ Inpatient 2 ☐ EP/O	utpatient	Other	ome 5 X Residence	6 □Other (Specify)
Division of	ng Ph ter th	n: T		Time of Injury	28c. Injury at Work?	28d. Describe how inj	
<u> </u>	endir seth. or: Af he fu	atic	2 Accident investigation		M 1 Yes 2 No		
Ĭ	ter de lirect	Certification	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, for building, etc. (Specify)	arm, stre	et, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ite)
	pitel o		Manual Ma				
	Hos 24 ho Fun stely f	edical	29a. Certifier (Check only one) (Check only one) (Check only one)	e, death nd/or inv	occurred at the time, date and place, estigation, in my opinion, death occur	and due to the cause( red at the time, date ar	s) and manner as stated. nd place, and due to the cause(s)
	To the Hospitel or Attending Physicien: within 24 hours efter deeth. To the Funerel Director: After this certifics completely filled in by the funeral director.	Mec	29b. Signature and title of certifier		29c. License number		ate signed (Month, Day, Year)
	->-0		> Christopher a Tako, MO		0 34249	1	2/13/2004
	1/01	-	30. Name and address of person who completed cause of death (Item 23a)	(Type, F	Print)	1	
_	10.		CNRISTOPHER ZATACIMO 90			TIMORBI A	10 21236
	Sta		31. Date filed (Month, Oay, Year)  32. Registrar's Signature	4	don't		Iv.
	Registra	ir	DEC 1 3 2004	for	process		

State of Maryland / Department of Health and Mental Hygiene ? 39367 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** John Franklin Ritz Dec. 9 2004 3:03P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospital Center Westminster Carrol1 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** XIXIM 2DE 220-42-8290 Director 61 Nov. 6, 1943 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or iteme 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 🔀 🙀 No Director Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1600 Nicodemus Rd. 21136 death U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes XIXNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or iten eny injury or other traumatic event, the Mactical Examiral ance. Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes **2**CXNo Specify: If Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Supervisor Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Ritz ပ Grace Middleditch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrick Gleason/Companion 1600 Nicodemus Rd, Reisterstown, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 ☐ Burial XXCremation 3 ☐ Removal from State Metro Crematory Ind. 12/15/04 \*4 □ Donation 5 □ Other (Specify)

21. Signature of useral rvice Licensee Baltimore, MD 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician minute resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy ō in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached for ☐Yes 2☐No 9 Unknown 9 Unknown cate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 1 TYes or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: P Yes 2 🗌 No 1 Inpatient ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification; 28d. Describe how injury occurred After Division 5 Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the ! 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) December 10, 2004 D0051924 on who completed cause of death (Item 23a) (Type, Print) Herbert P. Henderson Jr. mp 2973 Manchester Rd Manchester 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Sale of

ORIGINAL

DHMH 17 Rev 1/2001

Amend Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 200 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Snyder Tohn December 10,2004 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Baltimore The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 23,1932 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 203-24-7917 **1**√2 M 2 □ F Yrs. 72 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pennsylvania York Hanover 1 Yes XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 102 Park Heights Blvd. 17331 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates: US Navy 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 1 ☐ Yes 💢 No Specify: Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Welder Welding Company 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Guy C. Snyder Catharine J. Moul 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 Parks Heights Blvd, Patricia A. Snyder/Wife Hanover, PA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ST. Mary's Cemetery 12/14/2004 Silver Run, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Myers-Durboraw Funeral Home, PA 91 Willis Street, Westminster, MD 21. Signature of Funeral Service 21157 23a. Perty Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis 2 weary disease or condition resulting in death) Due to (or as a consequence of) multi-organ failure 2 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consecuence of) 2 months Merhicillin-Resistant Staph Muraus Endocarditis resulting in death) Last Due to (or as a consequence of) Non Q-wave myocardial infarction 5 months IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No patient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1. Natural 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

certificate be executed and burial-1 Box 68760. the attending physician the ası 980 jo P.O. detached signed by Records, 99 peen has page certificate Division of Vital Attending Physician: this After death. the f the Funeral Director; in by t hours after ō Hospital filled within 24 the

Physician

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Medical Certification:

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> State Registrar

SUSANNA L MATSEN 31. Date filed (Month, Day, Year) DEC 1 3 2004

Albarra Matr

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

600 NORTH WOLFE STREET

29c. License number

PZS-000

BALTIMORE, MARYLAND 21287

29d. Date signed (Month. Dav. Year)

December 10, 2004

32. Registrar's Signature Beggeren

			_ For	State of Ma	aryland /	Departme	ent of Health and	Mental H	ygiene	e egibic.	
			1 - State Registrar			Certifica	ate of Death	1-0	Reg. Ng	2004	39369
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	/Medio Examir		4a. Facility Name (If not institution,		00		ty, Town, or Location of De		embe 40.	County of Dea	<del></del>
			Sinai Hosp	ital of R	saltim		Baltir		4	/	VA
	Funeral Director		212-38-1218	6. Sex 7. Ag	e (In yrs. last i	Yrs. Month	der 1 Year If Under 24 H is Days Hours M		lay, Year)	9. Big	Inptace (State or Foreign ountry)  MALYLAND
	yland now		Usual Residence of Decedent  10a. State 10b. County	. / .	10c. City, To	own or Location					10d. tnside City Limits
	Ba-f sl	Director	MD /	V/A	B	ACTI	MORE C	ZTY			1 PYes 2 □ No
	ours after death with the Marylan rat', or Items 23a or 28a-f show Exarcities invast be notified at	Dire	10e. Street and Number	CASTET	DAM	101.	Zip Code	211	10g. Cit	izen of What Co	ountry?
	death	Funeral	11. Marital Status	12. Was Decedent   Armed Forces?	Ever in U.S.	13. Was De	cedent of Hispanic Origin?	(Specify Yes or N	lo-	14. Race - Ame	
36	s after , or lite	by Fu	1 Never Married 2 Marrie	ed 1 ☐ Yes 2 🗹			pecify Cuban, Mexican, Pu 2 No Specify:	eno Fican, etc.)		Btack, White	le, etc.
2-0036	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show policy Exercities from the notified at	ted b	3 Widowed 4 Divorced		16	Sa. Decedent's U	sual Occupation		16b. K	nd of Business	/Industry
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alti	permit. Pag Department Important: I any injury c		21. Signatur Funeral Service L		)	22. Name	and Address of Facility	40WELL	1 12	UNEX	AL HOME
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			23a. Fatt: Enter the risease, or a shock or heart allure. List of Immediate Cause (Final	only one cause on each lin	10/		ode of dying, such as card		arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as	- 1	cardia	e Inharets's	9			4 days
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	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequenc	e of):					
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9 X	res that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit	Physiclan/Med	IF FEMALE:	23c. If yes, outcome	of pregnancy				TI.	TO Date of del	
. Box	death e atter	iclar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 4 Pregnant at	2 Fetal dea					23d. Date of del Month	Day Year
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Division of	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director,	Certification:	3 Suicide 6 Could n 4 Homicide determin		ury - At home, c. (Specify)	farm, street, fact	ory, office	28f. Location City or To	(Street and	d Number or Ru	ıral Route Number,
_	spital		29a. Certifier 1 Certifying	Physician: To the best	of my knowled	ae, death occurre	ed at the time, date and pla	ce, and due to the	cause(s)	and manner as	stated
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only 2/ Medicat E	xaminer: On the basis of and manner sta	examination a	and/or investigation	on, in my opinion, death oc	curred at the time	date and	place, and due	to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier		Un.		9c. License number		29d. Dat	e signed (Monti	h, Day, Year)
,	1.		30. Name and address of person v	//	9D	(Type Print)	US-000		Decei	nber	11, 2004
	10		GITANA BRADA	HUSKA ITE,	MD	Sir	RES-000 pai Hospito	e of	Boli	h'mon	e
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			1 - For State Registrar	State of Ma	aryland / Depa	artment of F		•	giene Reg. N2.	101.	20070
			Decedent's Name (First, Middle, Las	t)			-	2. Date of De	ath	<i>[U4]</i>	3. Time of Death
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	/Medic Examir		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of D			nty of Death	2112
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	Funeral		5. Social Security Number 6. Se		e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Bird Min. (Month, Da	h y, Year)	9. Birthpi Coun	lace (State or Foreign
	Director		5/7-37-4703	M 2□F	_58 Yrs.			06 0			India
	land w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10	0d. Inside City Limits
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	r 28e	Director	10e. Street and Number			10f. Zip Code		T	10g. Citizen	of What Coun	try?
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	ems Fra	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.			? (Specify Yes or No uerto Rican, etc.)	- 14. F	Race - America Black, White, 6	
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Maryland	and and em		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailir	g Address (Street	and Number o	r Rural Route Numbe	er, City or To	wn, State, Zip	Code)
	s 1 and 2 f Health item 27 I		Shehzad A. Shai	kh-Son	3523	16th S	t. N.V	W. Wash	ingto	n. DC	20010
altimore,	of of Tir		20a. Method of Disposition  1∑ Burial 2 □ Cremation 3 □	Removal from State	20b. Place of Dispo cemetery, cren	sition (Name of natory or other plac		Date	20c. Location	on - City or Tov	vn, State
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Bal	permit. Pag Department Important: I any injury o		21. Signature — uneral Service Licen:	1º Ball	and M	Name and Addre	ss of Facility H West	F/H Wes	st		
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Вох	death certific e attending p d for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy		U		Date of deliver Month	<b>y</b> Day Year
Ö	the de y the a	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□ Unknown	time of death 5L	Other (specify)					,
۵.	that the de ned by the s detached f		Part II. Other significant conditions co	intributing to death be	ut not resulting in the ur	iderlying cause give	en in Part I.	23e. Did to	bacco use c	ontribute to the	a cause of death?
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Vital	icien: T certificat ector, pa	e C	25. Was case referred to medical				26 Place of	1 ☐ Yes  Death (Check only or	2ENo	1 Yes	2 □ No
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	To the Hospitel or At within 24 hours after o To tha Funerel Direct completely filled in by	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best of iner: On the basis of and manner sta	of my knowledge, death examination and/or inv	occurred at the timestigation, in my or	ne, date and pi pinion, death o	lace, and due to the o occurred at the time, o	ause(s) and late and plac	manner as sta e, and due to	ted. the cause(s)
	To the A within 24 To the F complete	Mec	29b. Signature and title of certifier	and manner sta	neu.	29c. License	number		29d. Date sig	ned (Month, D	lav. Year)
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	- 2-1	-	30. Name and address of person who c	ompleted cause of di	eath (Ilem 23a) (Type I	Print)	7110	רבון	-126	6/200	7
	- 5		Kimbe	AT	Eche :	22 Sa	ith (	o435	St.		
	Sta	te	31. Date filed (Month, Day, Year)		ar's Signature	/					
	Registr	ar	DEC 1 3 2004	La mer	My My	South.	/				

			1_ For State of	•	epartment of He		ntal Hygier	ne 2001	00071
			Registrar  1. Decedent's Name (First, Middle, Last)	(	Certificate of D		Reg. I	<u>16004</u>	3 9 3
	Physici		, , ,	arshall	Shi	pley		8,2004	1015 9 M
	/Medic Examin		4a. Facility Name (If not institution, give street and num		4b. City, Town, or I			4c. County of Deat	h
l/s			Maryland General	Lospital	Baltim	ore Cr	Ly		
- T	Funeral Director		M7M 2□ F	7. Age (In yrs. last birth	Months Days	Hours Min.	Date of Birth (Month, Day, Yea	9. Birtl	hplace (State or Foreign untry) MID
	ס		216-20-2774 Usual Residence of Decedent	7.5			71 23	23	10
	show	<u> </u>	10a. State 10b. County	10c. City, Town					10d. Inside City Limits
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	aa or	1 Dir	1714 North Fulton Av		10f. Zip Code	.217	109.1	Citizen of What Co	
	death ims 2:	nera		dent Ever in U.S.	13. Was Decedent of His If Yes, specify Cuban		fy Yes or No-	U.S. A	rican Indian,
38	or Ita	by Fu	1 ☐ Never Married XX Married 1 ☐ Yes If Yes, Give	₹No	1 Yes 2 No	Specify:	can, e(c.)	Black, White	
200	tural,		3 ☐ Widowed 4 ☐ Divorced Year or Da	tes:	ecedent's Usual Occupat	tion	16h	B SKind of Business/	lack
35.	within 72 hour ene. than "natural	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-		Give kind of work done du ife. DO NOT use retired)	uring most of working	100.	Talle of Desiriose	industry
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and	be fill ad oth evan	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name (		en Sumame)	
Z Z	2 should be filed within 72 hours after death with the Marylan and Mental Hyglene. is marked other than 'natural', or Itams 23a or 28a-f show air marked other than 'natural', or Itams 23a or 28a-f show aumatic event. It e Modical Examinations and the notified at	7	William Shipley  19a. Informant's Name/Relationship (Type, Print)	19b. N	Mailing Address (Street an	Gertrude		or Town State 7	in Code)
3≥	and 2 sealth ar n 27 is nar trau		Hazel Shipley-Wife		4 North F				
Se,	es 1 a of Hei		20a. Method of Disposition  1 Degral 2 Cremation 3 Removal from S	20b. Place of D	Disposition (Name of crematory or other place)	Dat		Location · City or	
altimore	Pages Iment of I tant: If it jury or o		`4 ☐ Donation 5 ☐ Other (Specify)	King_N	Memorial P		.5/04 Ra	ndallst	own, Md
Ball	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Itams 23a or 28a-f show any injury or other traumatic event. It's Modical Externitivational Learning once.		21. Signature of Funeta Service Licensee	Imes)	22. Name and Address March F/H 4300 Waba		Baltimo	re. md	21215
			23a. Part1. Enter the disease, or complications that of shock, or heart failure. List only one cause or ear	used the death. Do no ch line.	t enter the mode of dying,	, such as cardiac or r	espiratory arrest,		Approximate Interval Between
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of Vital Records,	- v -	ed by	Part II. Other significant conditions contributing to de	ath but not resulting in t	ne underlying cause given	nin Parti.	1 Tes		the cause of death?  bably 4 Dunknown
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of	Phys or this oral di	: To	27. Manner of Death 28a. Date o	Injury 28b. Tin	ne of 28c. Injury a	at 28	5 Residence  d. Describe how in		ify)
ion	inding F ath. r: After ie funera	atio	2 Accident investigation	, <i>Day Year)</i> Inji		es 2 No			
Division	To the Hospital or Attending Physician: The within 24 Hours after dash.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be determined 28e. Place building	of Injury · At home, farm g, etc. <i>(Specify)</i>	, street, factory, office	28	Location (Street City or Town, Sta	and Number or Ruite)	ral Route Number,
	spital		29a. Certifier 12 Certifying Physician: To the	pest of my knowledge,	death occurred at the time	a, date and place, and	d due to the cause	s) and manner as	stated.
	he Ho in 24 h ha Fu pletely	edicai	(Check only one) 2 Medical Examiner: On the ba and mann	sis of examination and/	or investigation, in my opin	nion, death occurred	at the time, date a	nd place, and due	to the cause(s)
	To T Com	Σ	29b. Signature and title of certifie	2	29c. License	number	29d. D	ate signed (Month	, Day, Year)
			" Willes		894	£78	/	2/8/04	A
	2		30. Name and address of person who completed cause thick on wukin, in	- 0 4 90 1	aryland	Grenera	Il No	spital	
	Sta		31. Date filed (Month, Day, Year) 32/Re	gistrar's Signature	Loads		1	-1	
	Registr	ar	DEC 1 3 2004	/-	//				

		ľ	State of Maryland / Department of State of Maryland / Department of Certificate		nd Mental Hy	/giene 20	04 39372
	Physici		1. Decedent's Name (First, Middle, Last) DENNIS M. STURGILL, JR.		2. Date of Do Month 12		Year 7:00A <sup>M</sup>
	/Medio Examin		Harford Memorial Hospital Havre	own, or Location of December 2	Death <b>e</b>	4c. County o	
	Funeral Director		5. Social Security Number  212-32=0376  6. Sex 1		Min. 8. Date of Bi (Month, D) 11/19	ay, Year)	Birthplace (State or Foreign Country)  [aryland]
	r 28a-f ehow	tor	10a. State 10b. County 10c. City, Town or Location MD Harford Darlington			- 4,	10d. Inside City Limits 1 ☐ Yes 2 No
	th with the Ma 23a or 28a-1	ai Director	10e. Street and Number 10f. Zip Co 3746 Dublin Road 2	ode 21034		10g. Citizen of WI	•
A. M.	er dea Itema	ed by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent If Yes, specify  15. Decedent's Education  16. Decedent's Usual C	No Specify:	n? (Specify Yes or N Puerto Rican, etc.)		- American Indian, , White, etc.  White
54 0700 A.1	d within 72 giene.	Completed		done during most o	f working		Mill
	Idi yidiid Kif. 2 should be filed within and Mental Hygiene. ie marked other than aumatic event, tte M.	To Be C	17. Father's Name (First, Middle, Last)  Dennis M. Sturgill	Lo	Name (First, Middle ra Mae Woo	odie	
5/04	and 2 sh and 2 sh ealth and m 27 ie m			ecroft Dr	ive, Havre	e de Grac	e, MD 21078
12/5/6	Page ment o ant: if		20a. Method of Disposition  1 XBurial 2 □ Cremation 3 □ Removal from State  1 □ Donation 5 □ Other (Specify)  20b. Place of Disposition (Name cemetary, crematory or othe Darlington Cemetary)	etery 1:	Date 2/9/2004	Darling	ton, MD
/ 2	permit. Departition of the property and injury injury injury once.		Harking Fu				Approximate
DENNIS	Cate be executed // Medical Examiner    Ithe burial-transit    Ithe	Examiner	shock, of heart failure. List only one cause on each line.	emorrh			Interval Between Onset and Death 3 day 5
URgill, D.	death certif	Physician/Medical	d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  d.  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregrate time of death 5 ☐ Other (specific pregnant) 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnant at time of death 5 ☐ Other (specific pregnant) 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnant at time of death 5 ☐ Other (specific pregnant) 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnant at time of death 5 ☐ Other (specific pregnant) 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnant at time of death 5 ☐ Other (specific pregnant) 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnant at time of death 5 ☐ Other (specific pregnant) 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnant at time of death 5 ☐ Other (specific pregnant) 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnant at time of death 5 ☐ Other (specific pregnant) 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnant at time of death 5 ☐ Other (specific pregnant) 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnant at time of death 5 ☐ Other (specific pregnant) 2 ☐ Color of the color of the			23d. Date Mont	of delivery th Day Year
	v requires that been signed by should be deta		Part II. Other significant conditions contributing to death but not resulting in the underlying cause Hypertensis	se given in Part I.			bute to the cause of death?  3 Probably 4 Unknown
	vital necolidation: The law requirectificate has been rector, page 2 should	Completed by			24a. Was auto perf 1 \sum Yes	formed?   de	ere autopsy findings available ior to completion of cause of eath?
of Vito	ding Physician: The Tr. After this certificate h funeral director, page	To Be	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital: 1 SInpatient 2 ER/Outpatient 3 DOA  27. Manner of Death  28a. Date of Injury 28b. Time of 28c.	Other: 4 🗌 Nursi	f Death (Check only ing Home 5 Res		
Service of With Bosonia	To the Hospital or Attending Routing 4 hours after death. To the Funaral Director: After completely filled in by the funaral	Certification:	27. Manner of Death  1  Natural 5 Pending investigation  3 Suicide 4 Homicide 28e. Place of Injury (Month, Day Year)	c. Injury at Work? 1  Yes 2 No	28f. Location		r or Rural Route Number,
	the Hospit in 24 hours the Funara pletely fille	Medical C	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, death occurred at to the basis of examination and/or investigation, in and panner stated.	my opinion, death		, date and place, ar	nd due to the cause(s)
•	with To I	M		License number 47746		29d. Date signed 12/5	(Month, Day, Year)
ı	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Thom AS BURKE MD 501 S. UNION.  31. Date filed (Month, Day, Year)  32. Registrar's Signature A	AVE H	Aure de	GRACE	104 ,MD. 21078
	Sta Registi		31. Date filed (Month, Day, Year) DEC 1 3 2004 32. Registrar's Signature A	Kal			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are L	Legible.
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		1	For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of H <i>rtificate of L</i>		_	ene2004	39373
	Physici		Decedent's Name (First, Middle		Earl Smith			2. Date of Death Month	Day Year	3. Time of Death 4:57 p
	/Medic Examin		4a. Facility Name (If not institution	n, give street and number)		4b. City, Town, or	Location of Death		4c. County of Death	
	Funeral Director		5. Social Security Number	roll County Gener 6. Sex 1 M 2 ☐ F	al Hospital e (In yrs. last birthday) 59	If Under 1 Year Months Days	Wes If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birth	arroll place (State or Foreign intry)
	pug *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation		August 31,		Maryland  10d. Inside City Limits
	Manyli 1 sho	to		Carrell		0	o demonstille			1 ☐ Yes 2 X No
	th the	Director	Maryland  10e. Street and Number	Carroll		10f. Zip Code	ykesville	10	g. Citizen of What Cou	intry?
	ath wi		2162 Cimarron Plac				21784		U.S	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is markad other than "natural", or Items 23e or 28e-1 show important: If Itam 27 is markad other than "natural", or Items 23e or 28e-1 show all yilly or other traumatic event. The Madical Examiner rount is notified at once.	by Funeral	11. Marital Status  1 Never Married 2 Marriad 3 Widowed 4 Divorced	if Yes Give	No	Was Decedent of Hilf Yes, specify Cuba 1 ☐ Yes 2 DNo	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify:	
21215-0036	72 ho	Completed		t's Education st grade completed)	(Give	dent's Usual Occupa	during most of work	ting 1	6b. Kind of Business/Ir	
121	within ane. than "	mpl	Elementary/Secondary (0-12)	College (1-4or 5	i+)	DO NOT use retired	,		La	abor
	Hygie other ent. It	Be Co	17. Father's Name (First, Middle,	Last)		vvaren	ouse Worker 18. Mother's Nam	e (First, Middle, M	laiden Sumame)	
Maryland	2 should be filed withir and Mental Hygiene. Is markad other than aumatic event. The Ma	To B	Charle	es Cunningham				Lucy L	ouise Peugh	
/ar	2 sho and f is me		19a. Informant's Name/Relations	hip (Type, Print)	19b. Maili	ng Address (Street a	and Number or Rur	al Route Number,	City or Town, State, Zi	p Code)
	1 and 2 Health tam 27		Mrs. Frances M. S	Smith Wife	20b. Place of Dispe	2162 Cimerror osition (Name of		sville, Maryla Date 2	nd 21784 0c. Location - City or T	own, State
altimore,	Pages nent of t		1 Durial 2 Cremation 4 Donation 5 Other (5			matory or other place gc Mcmorial F z. Name and A. dres	12	/11/2004	Elkridge,	Mandand
Balti	permit. Pag Department Important: I any Injury o once.		21. Signature of Funeral Service	Nation Khini	. <b>D</b> Λ		•			
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each li	the death. Do not en	ter the mode of dyin	d Columbia g, such as cardiac	Pike Ellicott	City, MD 21043	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	_a_met	Astahic	Small (	cell ca	rzcinom	A LUNG	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):					
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of):					
	icate be executed physician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C						
60,	icate be executed physician and s the burial-transit	al Ex	resulting in death) Last	Due to (or as	a consequence of):					
68760,		edical		d						
P.O. Box	law requires that the death certific as been signed by the attending p 2 should be detached for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a' 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of deliv Month	very Day Year
	w requires that been signed t should be deta	by	Part II. Other significant conditi	ons contributing to death b	ut not resulting in the u	underlying cause give	en in Part I.	23e. Did toba	acco use contribute to to s	the cause of death?
Il Records,	The ate ha	Completed						24a. Was an autopsy perform 1 Yes 2	ed/? prior to co	opsy findings available ompletion of cause of
Vital	Physician: The this certificate har al director, page	Be	25. Was case referred to medica examiner?	Hospital:		oth		h (Check only one		
of		7: To	1 Yes 2 No 27. Manner of eath	28a. Date of Inju (Month, Da		nt 3 DOA	4 Li Nursing Ho	ome 5 ☐ Resider 28d. Describe hov	nce 6 Other (Speci w injury occurred	fy)
ion	Attending P r death. sctor: After t by the funers	atlo	1 ZNatural 5 ☐ Pendir 2 ☐ Accident investi	igation	y Year) Injury		Yes 2 □No			
Division	al or Atte	Certification:	3 Suicide 6 Could 4 Homicide determ	nined 200. Flace of III	ury - At home, farm, st c. (Specify)	reet, factory, office		28f. Location (Stre City or Town,	eet and Number or Rur State)	al Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifyin (Check only one) 2 Medicel	ng Physicien: To the best Exeminer: On the basis of and manner st	f examination and/or in	th occurred at the tin	ne, date and place, pinion, death occur	and due to the cau	use(s) and manner as s te and place, and due t	stated. to the cause(s)
)	To the within	Σ	29b. Signature and title of certific	mcok- E	cors III	29c. Licens	e number 231660		d. Date signed (Month,	
	10		30. Name and address of person	who completed cause of o		Print)			es minus	er macular
100	Sta Regist		31. Date filed (Month, Day, Year, DEC 1 3 20		ar's Signature	Sparker				

GAM 04-7720 Annabelle Shinaberry

			For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of He rtificate of D	ealth and M Death	lental Hy	giene () ()	4 39374
	Physici	an	1. Decedent's Name (First, Middle Annabell Shin					2. Date of De Month Decembe	_	3. Time of Death 2004 11:30 A <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution,			4b. City, Town, or I		Decembe	4c. County o	
	ZAGIIII		214 North Main			North E			Cecil	-
	Funeral Director		278-24-9120	6. Sex 7. Age 1	(In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bird (Month, Da Feb 14	th 1929	9. Birthplace (State or Foreign Country) West Virginia
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation		-		10d. Inside City Limits
	Mary a-1 sh	tor	MD Ce	cil	Nort	h East				1 □Yes 2X No
	h with the Maryland 3a or 28a-f show st be cattified at	al Director	10e. Street and Number 214 N. Main S	reet Extende	ed	10f. Zip Code	21901		10g. Citizen of WI	•
920	72 hours after death with the Maryland natural', or Itams 23a or 28a-1 show deal Examerre usi be rediffed at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ፟፟፟ Marri 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Evaluated Armed Forces? 1 ☐ Yes 2 ▼ Note 1 Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 🛣 No	spanic Origin? (Spin, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Race Black Specify:	- American Indian, K, White, etc. white
Maryland 21215-0036	rithin 72 hours ne. han "natural", e Mudical Ex.	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)		(Give	dent's Usual Occupation of work done du DO NOT use retired)	uring most of work	ing	16b. Kind of Bus	
2	filed within Hygiene. other than	CO	17. Father's Name (First, Middle, I	<u> </u>				e (First, Middle,	. Maiden Sumame	
an	lid be lental kad o	To Be	William Ben				Grace 1	Mae Bow	man	,
ary	12 should be filed within 7 h and Mental Hygiene. 7 Is markad other than " traumatic evant, the Mod	-	19a, Informant's Name/Relationsh			ng Address (Street ar				State, Zip Code)
Z,	and 2 ealth m 27 I		Gene Shinaberr	y/son	602 20b. Place of Dispo	Sally Co		na, DE		
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If itam 27 Is marked any injury or other traumatic en <u>once.</u>		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☒ Donation 5 ☐ Other (Sp	ecify)	cemetery, cre	matory or other place	)			City or Town, State
Ball	permit. Departr Imports any inju		21. Sixture of Funeral ryice of Funeral ryice	icensee Warte	tor 2	State Anat Baltimore,	omy Boar MD 212	d 655 W 01	. Baltim	ore Street
	Physician /Medical		23a. Part Enter the disease, or shock or heart failure. List of the cause (Final disease or condition resulting in death)	a. MULTIPLE		ter the mode of dying		or respiratory a	rrest,	Approximate Interval Between Onset and Death
Ŀ	Examiner	er	Sequentially list conditions, if any, leading to immediate	b	consequence of):			_		
	cuted od ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	G						
68760,	icate be executed physician and s the burial-transit	edicai Ex	resulting in death) Last	Due to (or as a	consequence of):					
_		Med	IF FEMALE:						T.	
O. Box	The law requires that the death certificate has been signed by the attending lage 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☑ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Petal death 3	Ectopic pregnancy Other (specify)			23d. Date Mont	of delivery th Day Year
, P.O	res that the igned by be detact	by Ph	Part II. Other significant condition	ns contributing to death but	t not resulting in the u	inderlying cause give	n in Part I.	23e. Did to	obacco use contrib	bute to the cause of death?
rds	w requires been sign should be							101	Yes 2⊉No 3	3 ☐ Probably 4 ☐ Unknown
Division of Vital Records,	The law recate has been page 2 sho	Completed						24a. Was autop perfo 1 Yes	osy propried? pr	fere autopsy findings available ior to completion of cause of sath?  ☑ Yes 2 □ No
ita	ilcian: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?				26. Place of Deat			27.00 22.10
of V	Physic this ce al dire	은	1X Yes 2 □ No		t 2 ER/Outpatie		4 LI 14013#19 710			r (Specify) SCENE
ou c	fter	Certification;	27. Manner of Death  1 Natural 5 Pending investig		Year) Injury	Work	at ? ′es 2,≰INo		how injury occurred	
/isi	Attandi death ctor: A	fical	3 ☐ Suicide 6 ☐ Could r	12/1/0	y - At home, farm, sti (Specify)	reet, factory, office				r or Rural Route Number,
Ö	s after	Certi	4 Amnicide determine		(Specify)		2	City or Tov	INST NO A	RTHEAST MD
	To the Hospital or Attandi within 24 hours after death. To the Funaral Diractor: A completely filled in by the fu	Medical (		Physician: To the best of examiner: On the basis of and manner state	examination and/or in					
	To the within To the comp	M	29b. Signature and title of certifier	D		29c. License O.C.			29d. Date signed ecember	(Month, Day, Year) 02, 2004
			30. Name and address of person	who completed cause of de	ath (Item 23a) (Type	Print) Penn Str	eet, Bal			
	Sta		31. Date filed (Month, Day, Year)	32. Registrar	r's Signature	porks		. <u> </u>		
	Regist	ar	DEC 1 3 200	1	1- 1-1					

CPM 04-07719 Alvie Shinaberry

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		_	1 - For State Registrar				tificate of			Reg. I	/ 11	04	39375
	Physici	an	1. Decedent's Name (First, Middle,	Last)					2. Date of Month		Qay	_Year	3. Time of Death
	/Medic		Alvie Shinaberr						Decem			2004	11:30 aм
	Examin	er	4a. Fecility Name (If not institution, 9214 North Main S				4b. City, Town, o North		of Death	1	4c. County Ceci		
	Funeral			. Sex 7. A		last birthday)	If Under 1 Year	If Under	24 Hrs. 8. Date of	Birth		9. Birthol	lace (State or Foreign
	Director		232-36-6615	1XM 2□F	76	Yrs.	Months Days	Hours	24 Hrs. 8. Date of Min. July	30°, 1	928	West	Virginia
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10	0d. Inside City Limits
	Marylan -1 show Illed at	tor	MD Cec	i1		Nort	h East						1 □Yes 2X No
	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "neturel", or items 23e or 28e-f show or other treumetic event, the Medical Examinar must be multiled at	Funeral Director	10e. Street and Number 214 N. Main St	reet Exten	ded		10f. Zip Code	219	901	10g. (	Citizen of V	What Coun	try?
	ems 2	ner	11. Marital Status	12. Was Decedent	Ever in U.	S. 13.	Was Decedent of H	lispanic Ori	gin? (Specify Yes o	No-		e - America	
36	s after	by Fu	1 ☐ Never Married 2 🔯 Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1∭XYes 2 ☐	No		1□Yes 2XINo	Specify:			Specify	1_	ite
21215-0036	thour sture!	ed b	15. Decedent's	Year or Dates: Education	45-6	16a. Dece	dent's Usual Occup	ation		16b.	Kind of Bu	usiness/Ind	dustry
215	hin 72. 9. 9n "ne	Completed	(Specify only highest	grade completed) College (1-4or	5+)	(Give	kind of work done DO NOT use retired	during mos d)	t of working				
	ygien ygien her th	Con	Elementary/Secondary (0-12)	2			salesman				anspo		Lon
Maryland	12 should be filed within "h and Mental Hygiene." F is marked other then "Ireumetic event, Its Med	To Be	17. Father's Name (First, Middle, La Bedford Lee Shi						er's Name <i>(First, Mic</i> 1 <b>cillia</b> G1		en Sumam	16)	
lary	2 sho and h is ma		19a. Informant's Name/Relationship						er or Rural Route Nu			State, Zip	Code)
	1 and 2 Health Iem 27 i		Gene Shinaberry  20a. Method of Disposition	/son	20b. P		Sally Col	irt Sn	nyrna, DE	-	Location -	City or To	wn State
Baltimore,	Pages nent of I ent: If ite ury or o		1 ☐ Burial 2 ☐ Cremation 3 1 ☑ Donation 5 ☐ Other (Spe			emetery, crer	natory`or other plac	ce)				,	
Balt	permit. Pages Department of Importent: If i eny injury or once.		21. results of Euneral S rice Li	ensee alle,	ctor		Ate Anatologicate Atlanto		ðard 655 1 21201	й <b>.</b> Ва	1timo	ore S	treet
			23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that cause nly one cause on each	d the death					y arrest,			Approximate Interval Between
	Physician	k ii	Immediate Cause (Final disease or condition resulting in death)	a. JATRACK	AL G	WNS HO	T WOUND	01	F HEAD			- 8	Onset and Death
	/Medical Examiner		rooding in doding	Due to (or as	s a consequ	uence of):							
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	s a consequ	uence of):							
	ocuted nd transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c									
,09	be executed sician and burial-transit	icai Ex	resulting in death y cast	Due to (or as	s a consequ	uence or):							
68760	ificate g phys as the			d									
Вох	death certificate be executed e attending physician and od for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	Ideath 3□	Ectopic pregnancy Other (specify)	1			23d. Dat Mor	e of deliver	ry Day Year
P.O.	it the d by the tachec	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown									
Records, F	The law requires that the de ate has been signed by the a page 2 should be detached t	by	Part II. Other significant condition	s contributing to death	but not resi	ulting in the u	nderlying cause giv	en in Part I.		id tobacco			e cause of death? ably 4 □Unknown
ecol	e law require has been sig je 2 should b	Completed							24a. V	∕as an utopsy		prior to com	osy findings available
E B	: The l	Con								erformed?	, c	death?	2□ No
Vital	Physicien: Th this certificate ral director, pag	) Be	25. Was case referred to medical examiner? 14 Yes 2 □ No	Hospital: 1 ☐ Inpat		50/0.4	Oth		of Death (Check or		- 000		COENE
of		n: To	27. Manner of Death	28a. Date of Inj (Month, Da		28b. Time of	I 3 DOA	4 🗆 IVU	rsing Home 5 🗆 F				SCENE
ion	ttending P death. ctor: After i y the funera	atio	1 □ Natural 5 □ Pending investiga	tion TOUND 12/	1104	For MD 11:2	.6 AM 1	Yes 2 ☑	No SVBT	TOT	SHOT	r se	LF
Division	for Attendate death Director: In by the	Certification:	3 Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad 280. Place of it		me, farm, str	eet, factory, office		City or	Town, Sta	ate)		Route Number,
Q	urs af urs af arel D		45 0-45		DEN				214 N				
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	Medicai	29a. Certifier Certifying (Check only one) Medical E:	Physician: To the best caminer: On the basis and manner s	of examina tated.	tion and/or in	restigation, in my o	ne, date an pinion, dea	d place, and due to th occurred at the tir	ne, date a	(s) and ma ind place, a	and due to	the cause(s)
	To the To the Comp	Σ	29b. Signature and title of certifier	) `			29c. Licens	e number		29d. [	Date signed	(Month, E	Day, Year)
•			- Mes					.C.M.I	Ξ.	Dece	mber	02, 2	2004
			30. Name and address of person w	BIO, MD	death (Item			eet. F	Baltimore.	Mar	vland	1 2120	)1
	Sta	ite	31. Date filed (Month, Day, Year)	32 Regist	rar's Signa	ture			- ST STINGLE	LICIL	y Laik	. 414(	/ <u>.</u>
	Registr	ar	DEC 1 3 200	Berlin	01	D pl	parks					<del></del>	

State of Maryland / Department of Health and Mental Hygiene 39376 State Registrar AMEND ITEM #18 PER FH C839 1995 Gate Pf Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** December 10, 2004

4c. County of Death 5:40 A Marguerite H. Taylor /Medical 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Burtonsville Prince Georges Holy Cross Nursing & Rehab Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/19/1915 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 ☐ M 2 🕱 F West Virginia Yrs. 89 215-28-6856 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28a-f show rel', or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Maryland Prince Georges Laurel Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 307 Brock Bridge Road 20724 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Mo If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: φ White 3 ¥Widowed 4 ☐ Divorced "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) I'm Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth any injury or other treumstic event 2008. Be Harry K. Auvil Unknown ZORA MARSTILLER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Nancy Gatdula — Daughter 307 Brock Bridge Road Laurel Maryland 20724 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Oaklawn Cemetery 12/14/2004 | Baltimore, Maryland 22. Name and Address of Facility
David J. Weber Funeral Homes P.A. 21. Signature of Funeral Service Lice See 401 S. Chester Street Baltimore, Maryland 21231 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** troke WEEK /Medical Due to (or as a consequence of): Examiner ment 10 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 2 No 1 Yes 2 10 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 3 DOA this To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Matural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier December 17, 2004 3 AUREL, MARYLAND 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARMSTRONG, MD. AURELPARK 31. Date filed (Month, Day, Year)

DEC 1 3 32. Registrar's Signature State 2004 General. Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		Please 1	-			c. Ensure All	•	•	
		For State Registrar	State of Ma		partment of l e <i>rtificate of</i>	Health and Me Death		ene . No.2004	3937
		Decedent's Name (First, Middle, Last,					2. Date of Death	. 140 1	3. Time of Death
Physicia		JAMES		_	TILLM	(4 1)	DECEMB	Day Year	( 1 / UM
/Medica		4a. Facility Name (If not institution, give	street and number)			or Location of Death	10000	4c. County of Dea	
Examinie	-	NORTH WES	T 405 P	ITAL	RAN	VPALCS T	TOWN	BACT	IMORE
Funeral		5. Social Security Number 6. Se	7. Age	(In yrs. last birthda	y) If Under 1 Year	, , ,	8. Date of Birth	9. Bi	irthplace (State or Foreign
Director		242-76-3537 K	<b>X</b> M 2□ F	48 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y	56	NC
2		Usual Residence of Decedent		10- City Town					101 1-11 01 11
turel, or Items 23e or 28a-f show at Examinar must be notified at	70	10a. State 10b. County		10c. City, Town or					10d. Inside City Limits 1 ☐ Yes XXNo
Sa-f	ecto	MD Baltim	ore	Owing	s Mills		140-		
naturel, or Items 23e or 28e-f show idical Examinat must be notified at	直	10e. Street and Number	-		10f. Zip Code	1 3 7	109	J. Citizen of What C	-
18 23 Turi	Completed by Funeral Director	36 Windbluff Co	urt  12. Was Decedent 8	ever in U.S. 13	21]	L L / Hispanic Origin? (Spec	rify Yes or No-	U.S.A	
a de	'n	1 ∑Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔯 N	i i	If Yes, specify Cut	ban, Mexican, Puerto R	tican, etc.)	Black, Wh	
E S	by	3 Widowed 4 Divorced	If Yes, Give ** Year or Dates:		1 ☐ Yes 🌠 No	Specify:		Specify:	Black
ca	ted	15. Decedent's Edu	cation	16a. Dec	edent's Usual Occu	upation	16	b. Kind of Business	
matic evant, the Medical	ble	(Specify only highest grad	e completed) College (1-4or 5	+) Tnf	Ormation	n during most of working n Managem	ent	Diamond	Comic
2	mo.	12th grade	4yrs_	Spe	cialist		Ī	Distribu	
vant	Be (	17. Father's Name (First, Middle, Last)	-	_		18. Mother's Name	(First, Middle, Ma	iden Sumame)	
	20	Sherman Washin	gton Til	llman Jr	•	Peggie S	pearmar	า	
other traumatic		19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Ma	iling Address (Stree	et and Number or Rural	Route Number, C	City or Town, State,	Zip Code) 20769
ertra		Thomas E. Till	man-Brot			d Pointe			
t of		20a. Method of Disposition 1 ☐ Burial XIXCremation 3 ☐ F	Removal from State	20b. Place of Dis	position (Name of rematory or other pla	ace)	ate 20	c. Location - City o	r Town, State
ury o		*4 ☐ Donation 5 ☐ Other (Specify)		Metro C	remator	y Inc. 12	/13/04	Baltimo	ore, Md
eny injury or otl once.		21. Signature of Funeral Service Licens	88		22. Name and Addr March F	ress of Facility			
2 8		Smill	UK.	me	4300 wal	bash Ave,	Baltin	nore, Mo	21215
10		23a. Part1. Enter the disease, or composhock, or he failure. List only o	ications that caused ne cause on e roll lin	the death. Do not e	nter the mode of dy	ring, such as cardiac or	respiratory arrest	L.	Approximate Interval Between
ian		Immediate Cause (Final disease or condition				VLAR A			Onset and Death
ical		resulting in death)		a consequence of):		100			
ner		Sequentially list conditions,	b						
	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):					
Dollar-tiansii	am	Cause (Disease or injury that initiated events resulting in death) Last	s						
	a Ex	resulting in death) cast	Due to (or as	a consequence of):					
	lca		d						
TOI USE AS ITIES	by Physician/Medic	IF FEMALE:	20. 14						
5	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	Ectopic pregnand	су		23d. Date of de Month	elivery Day Year
	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□ Unknown	time of death 5	☐ Other (specify) _				
	Ph	Part II. Other significant conditions co	ntributing to death by	it not resulting in the	underlying cause a	iven in Part I	23e Did tobac	cco use contribute t	to the cause of death?
	by		15517	Y	andonying dadad g	Water Hart Land I.			Probably 4 Unknown
	Completed	7.000	0 ) ; .	-			-		
,	nple						24a. Was an autopsy performe	24b. Were a prior to	autopsy findings available completion of cause of
mector, page 2 s	Col						1 Yes 2		
	Be	25. Was case referred to medical examiner?	la anitali		0.0	26. Place of Death	(Check only one)		
2	P	TU Yes 21 No	lospital: 1 Pinpatie		ent 3 DOA	LOW THE RESERVE TO TH		ce 6 ☐Other (Spe	ecify)
unera	on:	27. Mann Death 1 atural 5 Pending	28a. Date of Injur (Month, Day	y 28b. Time Year) Injury	/ Wo		8d. Describe how	injury occurred	
completely filled in by the funeral director, <b>F</b>	Certification;	2 Accident investigation 3 Suicide 6 Could not be	an Division (In)			Yes 2 No	06 1 /04	-4	3 1 C
in by	ıti	4 Homicide determined	28e. Place of Inju- building, etc	ury - At home, farm, c. (Specify)	street, factory, office	2	City or Town, S		Rural Route Number,
lled						- 1		(-)	
completely filled	lica		ner: On the basis of	examination and/or		time, date and place, as opinion, death occurre			
mple	Medical	29b. Signature and title of gertified	and manner sta	illed.	29c. Licen	nse number	29d	. Date signed (Mor	nth. Day. Year)
8		Lob. Olgitatura and title of vertility	186	/ .1	7	7777			
		'		M	L. D.	1122	Pt	CUMBUR	10 2004
5		30. Name and address of person who c				DA DALIAA	115701.1.	11 242	>
~		LEONARD RICH ARDSON 31. Date filed (Month, Day, Year)	32 Panietre	ar's Signature	COURT RU	DAP RANDA	113 10090	NID 2113	, >
Sta <sup>.</sup> Registra			Fre and	-	1				
		DEC 1 3 2004	13 Buch Dogwood	19	A A a cold il				

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of M	aryland / Depa	artment of I			giene	
			Decedent's Name (First, Middle, Last)					2. Date of Dea	th ZUUL	3 Time al De th
	Physici /Medic		Alice Cameron Turn	er				December 1	Day Yea 8 2004	
	Examin		4a. Facility Name (If not institution, give s			4b. City, Town, o	or Location of		4c. County of De	
			Renaissance Garden				nsville			timore
	Funeral		5. Social Security Number 6. Sex	7. A	ge (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Month, Day	, Year)	Birthplace (State or Foreign Country)
	Director	,	025-05-4163 Usual Residence of Decedent		00			Sept. 1	5,1916 Ma	ssachusetts
	yland 10w		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	the Marylar 28e-f ehow	ctor	Maryland Baltimore		Catons	ville				1 ☐ Yes 2 No
	or 28	Olre	10e. Street and Number		222	10f. Zip Code			10g. Citizen of What	•
	s 23a	Funeral Director	709 Maiden Choice			21228				ed States
	ltam:	nue	11. Marital Status  1 ☐ Never Married 2 ☐ Married	1 DVac 200	Ever in U.S. 13.	Mas Decedent of I f Yes, specify Cub	dispanic Origii an, Mexican, I	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ar Black, W	merican Indian, hite, etc.
920	urs af	þ	3 Widowed 4 □ Divorced	1 □Yes 2X If Yes, Give Year or Dates:	110	1□Yes 2X∑No	Specify:		Specify:	White
5-0036	within 72 hours after death with the Maryland ene. than "heturel", or Itams 23a or 28e-f ehow is Medical Evir in eth mat be notified at	Completed	15. Decedent's Educ (Specify only highest grade	cation	16a. Dece	dent's Usual Occup kind of work done	oation	of working	16b. Kind of Busine	ss/Industry
21	ithin le.	nple.	Elementary/Secondary (0-12)	College (1-4or	5+) life.	DO NOT use retire	d)	a working	Baltimore	County
121	filed w Hygier other tl		12 4 17. Father's Name (First, Middle, Last)		scho	ol teach		s Name (First, Middle,	public sc	hools
and	ould be filed with Mental Hygiene arked other that atic event, II at	) Be	Section 1					+800007	waiden Sumame)	
Maryland	is 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. item 27 is marked other than "neturel", or Itams 23a or 28e-f eho other traumatic event, if a Medical Ever in action at the recitifical at	၉	Hugh Cameron  19a. Informant's Name/Relationship (Type)	oe, Print)	19b. Mailir	ng Address (Street		n Ferguson or Rural Route Numbe.	r, City or Town, State	a, Zip Code)
	1 and 2 Health ar em 27 Is		Elaine Deppe - dau	ghter	14 U	doque Co	urt, B	revard, Nor	th Caroli	na 28712-9269
J.	es 1 a of Hei		20a. Method of Disposition		20b. Place of Dispo	sition (Name of natory or other pla	ce)	Date	20c. Location - City	or Town, State
Ш	Pages nent of I ant: If its ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Bayview (			/10/2004	Baltimore	e, Maryland
Baltimore,	permit. Pages 1 and Department of Health Importent: If item 27 eny injury or other tr 2002.		21. Signature of Funeral Service License	"Zin	2	. Name and Addre		Hubbard F	uneral Ho	me, Inc. yland 21229
	500		23a. Part1. Enter the disease, or or pli shock, or heart failure. List on	cations hat cause	d the death. Do not ent	er the mode of dyi	ng, such as ca	ardiac or respiratory arr	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	OII GACITI	hronic	Bron	ich iti	` \$		Onset and Death
	/Medical		resulting in death)	Due to (or as	a consequence of):					fear,
	Examiner		Sequentially list conditions,							
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as	a consequence of):					
	be executed sician and burial-transit	xan	that initiated events cresulting in death) Last		a consequence of):					
8760,	ate be ex nysician he buria			ı.						
9	tificate ig phys as the	edic							- 100	
Вох	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant	3c. If yes, outcome		Ectopic pregnanc	v		23d. Date of d	
	e deal he att	sicis	in the past 12 months? 1 □ Yes 2 X No	4☐Pregnant a		Other (specify)	,		Month	Day Year
P.0	res that the de signed by the a i be detached f	Phy	9 ☐ Unknown * Part II. Other significant conditions con	tributing to death I	out not reculting in the u	aderhving cause an	on in Part I	23a Did to	hacco use contribute	to the cause of death?
ds,	signe	d by	Tarrii. Ottor significant conditions con	mbuting to death i	out not resulting at the u	idenying cadse giv	real) all real ( i.	1 <b>25</b> Y	_	Probably 4 Unknown
Ö	w require been si should I	ete						24a. Was a	n 24h Wara	autopsy findings available
Records,	eicien: The law s certificate has t lirector, page 2 s	Completed						autops perfori	sy prior t mged? death'	o completion of cause of ?
	an: T tificate or, pa	a	25. Was case referred to medical	-			26 Place o	1 ☐ Yes # f Death (Check only or	No 1 1 Y	es 2 No
of Vital	Physicien: this certificaral director.	To B	avaminer?	ospital: 1   Inpati	ent 2 ER/Outpatien	t 3 DOA Ctf		ing Home 5 ☐ Reside		pecify)
0	ding Phye		27. Manner of Death	28a. Date of Inju	ary Year) 28b. Time of Injury	28c. Inju	ry at )		ow injury occurred	
Sio	Attending r death. actor: After by the funer	catle	2 Accident investigation				Yes 2 □ No			
Division	or Att	Certification:	3 Suicide 6 Could not be determined	28e. Place of In building, e	jury - At home, farm, str tc. <i>(Specify)</i>	eet, factory, office		28f. Location (Si City or Town	treet and Number or . n, State)	Rural Route Number,
	pitel ours a erel L		29a. Certifier 1/2 Certifying Phys	icien: To the hest	of my knowledge, death	a coourad at the ti	mo data and	place, and due to the a	auca(s) and manner	an atotad
	To the Hospitel or Attending Physicien: The within 24 butus after death.  To the Funerel Director: After this certificate his Rempletely filled in by the funeral director, page	Medical		ner: On the basis of and manner si	of my knowledge, death of examination and/or in- ated.	estigation, in my	ppinion, death	occurred at the time, d	ate and place, and d	ue to the cause(s)
	To the within To the To the	₽ E	29b. Signature and title of certifier			29c. Licens	se number	2	9d. Date signed (Mo.	nth, Day, Year)
1	10/		M 1	しゃり		DY	744	) [	Eersh 8	,2004
4	) "		30. Name and address of person who co	mpleted cause of	death (Item 23a) (Type	Print) Cl	2010	(arre (	ortonsu.	ile mayin
	Sta	ite	31. Date filed (Month, Day, Year)	32. Regist	rar's Signature	<b>b</b>				
	Registr	rar	DEC 1 3 2004	Den en	J 14	party				

			For State Registrar	State of Maryland / De	partment of Health and ertificate of Death	Mental Hygier	
			Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year
	Physicia		Colin E. Thompso	in, Jr.		December	8, 2004 9:53 P
	/Medic Examin		4a. Fecility Name (If not institution, give st	reet and number)	4b. City, Town, or Location of Dea		4c. County of Deeth
			Ivy Hall Nursing		Middle Rive		Baltimore
1.0	Funeral Director	/3	722-16-4983	7. Age (In yrs. last birthda 76 Yrs	Months   Davs   Hours   Mir		ar) 9. Birthplece (State or Foreign Country) 1928 Pennsylvani
1	pue *		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Limit
	Aaryle r sho	5	Maryland N/A		Baltimore		1 ½ Yes 2 ☐ N
	28a	Directo	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?
	h with		4015 Parkside Drive	2	2120	6	U. S. A.
	deat	Funeral		Was Decedent Ever in U.S.     Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue</li> </ol>	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Bleck, White, etc.
3	s 1 and 2 should be filed within 72 hours atter death with the Maryland of Health and Membal Hygiene.  If Health and Membal Hygiene a few strangers or 28e-1 show then 21 s marked other than "natural", or items 23e or 28e-1 show other traumatic event, it a Medical Examinar must be notified at	by	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	1 Ø Yes 2 □ No If Yes, Give Year or Dates 1946 – 1947	1 ☐ Yes 2 ☑ No Specify:		Specify: White
	72 ho natur	Completed	15. Decedent's Educ (Specify only highest grade	completed) (G	cedent's Usual Occupation ive kind of work done during most of w	and the second	o. Kind of Business/Industry Vimed Forces
4	han han	Ig III	Elementary/Secondary (0-12)	College (1-4or 5+)	e. DO NOT use retired)  Artist	)	istiutue of Patholo
4	iled v Hygie ther t		12thGrade 17. Father's Name (First, Middle, Last)			ame (First, Middle, Maid	
	d be i	o Be	Colin E. Thompson	1 S#	Man	cella Barba	ura Lindner
<u> </u>	s should be filed with and Mental Hygiene Is marked other tha aumatic event, tre l	ပ္	19a. Informant's Name/Relationship (Typ		ailing Address (Street and Number or F		
~	and 2 ealth al n 27 is		Barbara M. Thompson	n (Dghtr) 401	5 Parkside Drive.	Baltimore,	Maryland 21206
ט	os 1 and 3 of Health Item 27		20a. Method of Disposition	20b. Place of Di	sposition (Name of crematory or other place)	Date 20c	Location - City or Town, State
	Pages nent of I int: If It		1 ☐ Burial 2 <b>∑</b> Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)		Crematory 12/1	10/2004 Ba	ltimore, Maryland
	artn orts inju		21. Signature of Funeral Service License	θ	22. Name and Address of Facility S		
۵	Department of the partment of		Buen a.	ville 1	3331 Brelins Lane,		
	Dhysisian		23a. Pert1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final	cations that caused the death. Do not e cause on each line.	enter the mode of dying, such as cardi	ac or respiratory arrest,	Approximate Interval Between Onset and Death
Pile.	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence of):	600	Α	
	Examiner			gangrene	(R) fest and	Closhidic	un dyficile 4-5 wtc.
=	7 =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):			· ·
Marine 1 "	ate be executed hysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	5-1-4			
,007	be execuician and purial-tran		1950king in doalin, cast	Due to (or as a consequence of):			
-	cate b physic the b	dicai					
ם אסם	at the death certificat I by the attending phy stached for use as th	Physician/Med	in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
j.	0 0 0	lysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown			
 T	requires that the leen signed by th hould be detache	by P	Part II. Other significant conditions con	tributing to death but not resulting in th	e underlying cause given in Part I.		co use contribute to the cause of death?
cords,	w require been sig should b		Severe PVD	, Demonte,	COVD	1 12 Yes	2 No 3 Probably 4 Unknow
ပ္သ		Completed	CAD D	M .		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Ī,	The I	E				performed 1 ☐ Yes 2 🖸	
Vitai	sician: The law certificate has t irector, page 2 s	Be C	25. Was case referred to medical examiner?			eath (Check only one)	
> 10	S 5	2	1 ☐ Yes 21 ☐ No			Home 5 Residence	
	ding Ph h. After th funeral	Certification;	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Tim		28d. Describe how	injury occurred
20	Attendi death. ctor; A y the fu	cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, farm		28f. Location (Stree	at and Number or Rural Route Number,
Uivision	after of Direction by	ertif	4 Homicide determined	building, etc. (Specify)	, stroot, lactory, office	City or Town, S	State)
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director; After completely filled in by the funer	edical C	29a. Certifier 1 Certifying Physical Examination	sicien: To the best of my knowledge, oner: On the basis of examination and/oner and manner stated.	leath occurred at the time, date and pla or investigation, in my opinion, death oc	ce, and due to the caus curred at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
	o the	Med	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month, Day, Year)
10	- S - O	1	MA M.D		2-3875	4 1	2-09-2004.
	6		30. Name and address of person who co		PASTERN B	LVD. M	D-21221
	C+	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	4		

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. ZUUL Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2004 ECEMBER /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTI MORE REHABILITATION EXTENDED CARE (In.yrs. last birthday) Yrs. 5. Social Security Number If Under 1 Year Months Days If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Hours NORTH ( Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 Is marked othar than "natural", or Items 23a or 28a-1 ahow any injury or othar traumatic evant, Tra Maritical Experiment until be indiffied at once. 10a. State 10b. County 10d. Inside City Limits Town or Location 1♥Yes 2 No Completed by Funeral Director 10g. Citizen of What Country? et and Number 12. Was Decedent Ever in U.S. 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Otban, Mexican, Puerto Rican, etc.) 1. Marital Status Forces? Yes 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. BLACK If Yes, Give Year or Dates: 3 - Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) MACHINIST 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sur. Be HAHE 19b. Mailing Address (Street and Number or Rupa) Route Number WIFE 20b. Place of Disposition cometery, crematory IUILLE 20c. Location - City or Town, State

OWINGS WILLS, MARY LAND 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) VAUGHN C. GREENE FUNERAL HOME 21. Signature of Funeral Service Licenses BATI MORE, WO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Upan disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** School telly life non-flicing if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. the t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 has autopsy 2 No Division of Vital Yes To the Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one)  $Hospital: \ 1 \ \square \ Inpatient$ Other: 9 1 ☐ Yes 2 X No 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 X Natural 5 Pending death. investigation 2 Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To tha Funaral D Medical M Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print), WROPA C: TAN 3900 LOCH PAVEN AURORA 0

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

3 2004

32. Registrar's Signature

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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#2 3 per ME G838 12/13/04 TT State of Maryland Bepartment of Health and Mental Hygiene) 0.01

Reg. No. 2004 Certificate of Death 12/4/2004<sup>3</sup>. Time of Death 4, 1207 A 1:07a 1. Decedent's Name (First, Middle, Last) 2. Date of Death December **Physician** Joseph Wheatley 1:07a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1509 E. Biddle Street Baltimore NA 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F 212-46-6639 58 Yrs Md. Director 1-16-46 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 le marked other than "naturat", or Items 23a or 28a-f show any injury or other traumatic event, If a Modical Examination traumatic event, If a Modical Examination is not be notified at ence. Baltimore 1 Yes 2 □ No NA Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21213 USA 1509 Biddle Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Baltimore, Maryland 21215-0036 ģ Specify: Black 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sanitation Baltimore City 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fil ment of Health and Mental H tant: If item 27 le marked ott Wheatley, Sr. Maudestine Haywood James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31078 646 Moncrief Rd., Roberta, Ga. Mia Tripp Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Mem Pk. 12-10-04 Arbutus, Md. Baltimore, Md. 21202 21. Signature of Funeral Service Licensee 22. Name and Address of Facility & lady March F.H. East 1101 E. North Ave. W arren 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Due if (or as a consequence of): ardiovascular Disease Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy Year Month Day signed by the at Id be detached for 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Syndrome I mounodeficiency 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 ☐ No 24a. Was an s certificate has b lirector, page 2 s autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other:  $_{4}$   $\square$  Nursing Home 5  $\square$  Residence 6  $\bigcirc$ Other (SpecifyAt SCENE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1XXYes 2 □ No Certification: To within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Naturat 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier O.C.M.E. December 04, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland, 21201 M 32. Registrar's Signature 31. Date filed (Month, Day, Year) DEC 13 State Registrar

			1 - For State Registrar	State of M	laryland / Do	epartment of Certificate of				हिंदि  . №.	04	39382
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Sv.	Examin	er	4a. Facility Name (If not institution, gi	e Ave.		Bal	n, or Location of			4c. Cc	ounty of Death	1
~	Funeral Director		215-74-9662	1 □ M 2 PM E	ge (In yrs. last birth 45	Months Da			of Birth th, Day, y 1–13	-59	9. Birth Cou	place (State or Foreign intry)  Md.
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	r Location						10d. Inside City Limits
	Mary Interior	tor	Md.	JA	Ва	ltimore						X Yes 2 No
	be filed within 72 hours after death with the Maryland that Hygiene. od other then "naturel", or tems 23a or 28a-f show event, the Medical Exarctor transite modified at	Director	10e. Street and Number 400 E. Lorriane	Ave.		10f. Zip Cod 212			10g	g. Citizer US	of What Cou	intry?
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336	or', or Ite	by Fur	1  Never Married 2  Married  3  Widowed 4  Divorced	Armed Forces 1 ☐ Yes 2 X If Yes, Give Year or Dates:	No	1 ☐ Yes 2X		i, Puerto Rican, el	ic.)	Sp	Black, White,	, etc. .ack
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lary	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship	(Турө, Print)		lailing Address (Str						o Code)
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Ore	ges 1 t of H if ite or oth		20a. Method of Disposition  1	☐Removal from State	cemetery,	isposition (Name of crematory or other	place)	Date			ion - City or T	
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n			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	polications that cause one cause on each	d the death. Do no line.	enter the mode of	dying, such as	cardiac or respira	tory arrest	t,		Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or a	a consequence of		/	,	-			,
ě.		<u></u>	Sequentially list conditions,	b. — Subtribute	s a consucuence of							
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0	the a	yslc	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4∐Pregnant a 9□ Unknown	at time of death	5 ☐ Other (specify	")				11101111	July 15a.
<u> </u>	that the de ed by the detached	/ Ph	Part II. Other significant conditions	contributing to death	but not resulting in t	ne underlying cause	given in Part I.	. 23e.	Did tobac	cco use	contribute to t	he cause of death?
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	ch		1 Model	WW X	MD	D	5/90	28	De	cel	mber 9	2004
	10		30. Name and address of person who Robert K. Roby 1		death (Item 23a) (Ty	pe, Print)	Svite	72 Boll	imon	cr	カカコ	215
	Sta	- 6	31. Date filed (Month, Day, Year)	32. Regist	rar s Signature	1 1						
	Registr	ar	HEP TO	.UU4 R	person !	Loa	Kal					

Robert Wood UNK 04-394 AKG 04-7798

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	04 <b>-</b> 7798	ľ	For State Registrar		tificate of L	Death	Reg. N	Z 111113	39383	
	Physici	an	Decedent's Name (First, Middle, Last)				Date of Death		3. Time of Death	
	/Medic	al	ROBERT E. WOOD		4) 0': T	Dec		, 2004	5:30 P M	
	Examir	er	4a. Facility Name (If not institution, give street and number) Woods near Mount Street and Walnut Sta	reet	Rising			c. County of Death Cecil		
	Funeral Director		5. Social Security Number 217~86~8946  Usual Residence of Decedent  6. Sex 1 ☑ M 2 ☐ F 38	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. 8. D Hours Min.	pate of Birth Wonth, Day, Year April 26	9. Birth Cou 7, 1966 M;	place (State or Foreign intry) aryland	
	yland now			. City, Town or Loc	ation				10d. Inside City Limits	
	e Mar	ctor	Maryland Cecil	North E	ast Cec	il Co.			1 ☐ Yes 2 ☐ No	
	ath with th	Funeral Director	10e. Street and Number 89 Ridge Run Rd.		10f. Zip Code	21901		10g. Citizen of What Country? USA		
Maryland 21215-0036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland ariment of Health and Mental Plygiene. ortant: If item 27 la markad other than "natural", or Items 23a or 28a-1 show injury or other traumatic event, If a Madical Examinal remaints a natified at a.g	ρ	11. Marital Status  1  Never Married 2  Married 3  Widowed 4  Divorced  12. Was Decedent Ever in Armed Forces?  1  Yes, Give Year or Dates:		Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 No	ispanic Origin? (Specify n, Mexican, Puerto Ricar Specify:	Yes or No- n, etc.)	14. Race - Ameri Black, White Specify: Wh	, etc.	
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ryla	d Ment d Ment narka natic	P	Jackson E. Wood  19a. Informant's Name/Relationship (Type, Print)	10h Mailin	- Add (Carana	Hildur E				
Ma			Hildur E. Rosinsky (Mother)			Rd. North (			p Code)	
Baltimore,	of Hea of Hea item		20a. Method of Disposition 20b		sition (Name of patory or other place			Location - City or T	own, State	
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Bal	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra		21. Signature of Fundamental Licensee			assahn Funer elair Rd. Ki	ngsvill	e, Md. 2	1087	
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Division	Hospital or Attending I 44 hours after death. Funeral Diractor: After tely filled in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - A building, etc. (Spe	1 / 1 -1	iu c j	28f. L	ocation (Street a City or Town, Stat RISI we	and Number or Rur.	al Route Number, WalnutSt	
	To the Hospital or Attending Physician: The tai within 24 hours after death.  To the Funeral Diractor: After this certificate has completely filled in by the funeral director, page 2	edicai (	29a. Certifier (Check only one)  Certifying Physician: To the best of my the part of the best of my and manner stated.	knowledge, death	occurred at the tim	ne, date and place, and d pinion, death occurred at	ue to the cause(	s) and manner as s	stated. o the cause(s)	
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	2+1		30. Name and address of person who completed cause of death (I	Wel 1		Street, Bal	timore,	Maryland	21201	
	Sta Registi		31. Date filed (Month, Day, Year) DEC 1 3 2004  32. Registrar's Signary	gnature	Sporks	j				

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	Examir	ier	0		STER	BALTI			N/A	ui .
	Funeral Director		5. Social Security Number 6. Se 218–42–7058		s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. 8. Date Hours Min. (Mo	e of Birth nth, Day, Yes	9. Bir	thplace (State or Foreign ountry)  aryland
	death with the Maryland ims 23e or 28a-f show rmust be colified at	ō	Usual Residence of Decedent  10a. State 10b. County  Maryland Carroll	10c. (	City, Town or Loc Westmi					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the N	Director	10e. Street and Number			10f. Zip Code		10a. C	Citizen of What C	
	h with		4015 Littlestown	Pike		211	58		United S	
	ems ?	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13. W	as Decedent of H	lispanic Origin? (Specify Yean, Mexican, Puerto Rican, e	s or No-	14. Race - Am	encan Indian,
9000	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23e or 28e-1 show other traumatic avant, I'm Medical Examinar must be refilled at	by	1 Never Married 2 Married 3 Widowed 4 ADivorced	1 ☑Yes 2 ☐ No If Yes, Give Year or Dates:	i	Yes 2 X No	Specify:			White
Maryland 21215-0036	2 should be filed within 72 hours and Mental Hygiene. is marked othar than "natural", surnatic avant, the Medical Exa	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	(Give k life. D		ation during most of working 1)		Kind of Business	•
d 2	filed v Hygie Ithar t		12 17. Father's Name (First, Middle, Last)	2	Con	sultant	18. Mother's Name (First,		Self-Emp	Loyed
rylan	hould be d Mental narked o	To Be	Harry Clement Wri		10h Mailine	Add (Cha)	Jacquelir	ne G. H	Mollie	
Ma	lth and 2 sl		Mary C. Wright /				and Number or Rural Route eet, Emmaus,			,
Baltimore,	Pages 1 and 2 nent of Health int: if itam 27 i		20a. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 □ F	20b.	Place of Dispos cemetery, crema	tion (Name of atory or other plac	Date	20c.	Location - City or	Town, State
Hi	그 문 발 등		' 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Fugeral Service License		odlawn (	Lenetery Name and Addre		-		Maryland
ñ	Depa Impo any is		> Spitand (	Smelle			нирраг ens Avenue, E	a rune Valtimo	ral Home	e, INC.
	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ilications that caused the de ne cause on each line.  a	Brain	the mode of dyin	g, such as cardiac or respire	atory arrest,		Approximate Interval Between Onset and Death 18 days
68760,	certificate be executed to the certificate be executed to the certificate as the burial-transit to the certificate as the burial-transit to the certificate as the burial-transit to the certificate as the	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Pulseless Due to (or as a conse	elec	trical	activity	Arres	. T	
O. Box	death certii e attending d for use a	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3 DE	ictopic pregnancy Other (specify)			23d. Date of de Month	ivery Day Year
<b>a</b>	requires that the een signed by th rould be detache	by Pl	Part II. Other significant conditions co	ntributing to death but not re	esulting in the unc	erlying cause give	en in Part I. 23e	. Did tobacco	use contribute to	the cause of death?
ord	w require been sig should b	led l	Diabetes, hyp	ertension,	PeriPher	al vas	ular	1 ☐ Yes	2 □ No 3 □ A	obably 4 Unknown
I Records,	S 0 4	Somple	disease, attio	d fibrillat	ion, h	y Perlip		Was an autopsy performed?	prior to death?	topsy findings available completion of cause of
of Vital	Physician: this certific al director,	Be (	25. Was case referred to medical examiner?				26. Place of Death (Check	only one)		
of \	Physi this c	2	T Tes 217 NO		ER/Outpatient	3□ DOA Oth	4 Nursing Home 5			cify)
_	Attanding I r death. actor: After by the funer	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Yes 2 No	scribe how inj		
Sio	# # # = =	2000	datamiaad	28e. Place of Injury - At building, etc. (Spec	home, farm, stree cify)		City	or Town, Sta	te)	iral Route Number,
Division	vital or Atta urs after de iral Diracto		4   Hornicide							
Division	the Hospital or Atti in 24 hours after de the Funaral Diracto npletely filled in by tl		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sician: To the best of my kr ner: On the basis of examir and manner stated.	nowledge, death on ation and/or inve	stigation, in my o	oinion, death occurred at the	time, date ar	nd place, and due	to the cause(s)
Division	To the Hospital or Attanding Physician: The law within 24 hours after death.  —To the Funaral Director Atter this certificate has completely filled in by the funeral director, page 2	Medical Certif	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	ner: On the basis of examir	nowledge, death a nation and/or inve	ccurred at the tin stigation, in my of 29c. License	oinion, death occurred at the	time, date ar	s) and manner as nd place, and due ate signed (Monti	to the cause(s)
Division	To the Hospital or Att. within 24 hours after to completely filled in by ti		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	and manner stated.	nation and/or inve	29c. License	oinion, death occurred at the	29d. D	nd place, and due	to the cause(s)

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State o	f Marylar		epartmer Certifica					g. No. U	) 4 (	393	85
	Physici	an	1. Decedent's Name (First, Midd Ethel Wyatt	fle, Last)						2	Date of Death Month Del em l	Day 2	Year /	3. Time of	Death M
	/Medio		4a. Facility Name (If not institution	on, give street and nur	nber) ,/		4b City	Town, or I	Location of	Deathy	1.	4c. County	of Death	),,	U
	Examir	ier	maryland 6	reneral	145	Ortal	Bai	tim	ORL	(1	44				
	Funeral		5. Social Segurity Number		7. Age (In yrs.		Months	r 1 Year Days	If Under 2 Hours	Min.	Date of Birth (Month, Day,	Year)_	9. Birthpla	ce (State c	or Foreign INK
	Director		215-84-6848 Usual Residence of Decedent	1 □ M 2 💢 F	45	Yr	S.			(	Oct 1,	1959			
	land ow	1	10a. State 10b. Count	у	10c. C	ity, Town o	r Location						100	l. Inside Ci	ity Limits
	Mary	ţō	MD			Balt	imore							1 <b>∑</b> Yes	2 🗌 No
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23s or 28s-f show int, the Madical Exercitant roast be notified at	Director	10e. Street and Number				10f. Zi	p Code			10	g. Citizen of	What Country	y?	
	ath w	rai	1217 W. Fayet						223				SA		
	er de	Funerai	The state of the s	nk 12. Was Dece Armed Fo	rces?	J.S.	13. Was Dece If Yes, spe	dent of His cify Cuban	spanic Orig n, Mexican,	in? (Specif Puerto Ric	y Yes or No- an, etc.)		e - Americar ck, White, etc		
36	Ir, or	by F	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	If Yes Giv	е	unk	1 🗆 Yes	2X No	Specify:			Specif	bla	ck	
215-0036	2 hou	ted		nt's Education		16a. D	ecedent's Usu	al Occupa	tion		unk   1	6b. Kind of B	usiness/Indu	stry	unk
215	thin 7 e. an "n	Completed	Elementary/Secondary (0-12)	est grade completed) College (1	-4or 5+)	- G	give kind of wi fe. DO NOT u	ise retired)	uring most	or working					
21	led w lygien her th		unk	unk	-		11	nk	10 Marks	d- No //	Time & Balanda Ba	laida a Cuma a	1		1-
Maryland 21	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene 1 the file of 1 same 23s or 28s-1 show item 27 is marked other than "natural", or items 23s or 28s-1 show other treamatic event, the Madical Exercitival regal Le notified at	o Be	17. Father's Name (First, Middle	, Last)			u	IIK	18. Mother	s Name (/	First, Middle, M	aigen Suman	16)		unk
ary	should be and Mental I s marked o umatic eve	ဥ	19a. Informant's Name/Relation	ship (Type, Print)		19b. M	lailing Addres	s (Street a	nd Number	r or Rural F	loute Number,	City or Town,	State, Zip C	ode)	
	1 and 2 Health a Iem 27 Is	1	Maryland Gener	ral Hospita					enue :		more, M	ID 212	.02		
<b>Éaltimore</b> ,	permit. Pages 1 and Department of Health Importent: If item 27 any injury or other tr <u>20ce.</u>		20a. Method of Disposition 1 □ Burial 2 □ Cremation	3 □Removal from	/   /	Place of D cemetery,	isposition (Na crematory or	me of other place	9)	Date	e 2	Oc. Location -	City or Town	n, State	
ij	t. Pag tment tent: njury		`4 □Donation 5 💆 Other (	Specify) in sta					1						
Bal	permit. Pages Department of Importent: If it any injury or o		21. Signature of Euneral Service RODALO	S Wada, A	jr st	r	State Baltin	Anato	omy Bo	ard 21201	655 W.	Baltim	ore St	reet	
	1913		23a. Pert1. Puter the disease, of	or complications that of	aused the dea	th. Do not					espiratory arre	st,	A	approximat nterval Bet	(e
	Physician		shock, or eart failure. Lis Immediate Cause (Final disease or condition	or only one cause to e	MPAC	deas	1 7	7-6	mts	(N)			Ċ	nset and	Death
	/Medical		resulting in death)	a. Dueso	or as a conse	quence of)	:	i iwi	1011						
	Examiner	_	Sequentially list conditions,	b. Dra	or as a conse	5									<del></del>
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	₹ Due to (	or as a conse	querice or)	•								
,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Examiner	that initiated events resulting in death) Last	c	or as a conse	quence of)	:								
8760,	ysiciau ysiciau ie buri			d											
99	ntifica ng ph as th	Medi	IF FEMALE:	11								1			
Вох	leath certifica attending ph I for use as th	lan/	23b. Was decedent pregnant in the past 12 months?		irth 2 🗌 Fet	al death	3 □Ectopic p						te of delivery inth D		Year
0.	that the death ed by the atte detached for	Physician/Medical	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregn 9□Unkno	ant at time of	death	5 Other (s	pecify)		-				,	
P.0	res that the igned by be detact		Part II, Other significant condit	tions/contributing to de	eath but not re	sulting in th	ne underlying	cause givei	n in Part I.		23e. Did tob	acco use conf	ribute to the	cause of c	death?
Records,	quires n sign ald be	d by	CIRRADSIS O	of the	Live	R					1 🗌 Ye	s 2 □ No	3 🗆 Probab	oly 4 🕏	Inknown
00	aw requir s been si 2 should	Completed		,							24a. Was an	24b.	Were autops prior to comp	y findings	available
$\alpha$	9 L 9	шо									autopsy perform 1 Tes 2	ed?	death?	Dietion of c	ause or
	ician: Th certificate rector, pag	BeC	25. Was case referred to medic examiner?	al					26. Place	of Death (0	Check only one	7			
of V	Physician: this certificatal director,	70	1 ☐ Yes 2 No			ER/Outp			4 LI NUI		5 🗌 Resider				
	ding P	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pend	iiig .	of Injury h, Day Year)	28b. Tim	ne of iry M	28c. Injury Work	at ? ′es 2∐N		d. Describe how	w injury occur	red		
Division	Attending or death. ector: After by the fune	icat	3 Suicide 6 □ Could		of Injury - At I	nome farm			Z [ ] N		. Location (Str.	eet and Numb	er or Rural F	Route Num	nber.
Ρį	ospitel or A hours after unerel Direc ly filled in by	Certification:	4  Homicide deter	mined buildi	ng, etc. (Spec	ify)	, , , , , , , , , , , , , , , , , , , ,	,,			City or Town,	State)			,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely illed in by the funeral director.	edical C	29a. Certifier 1 Certify (Check only one) 2 Medica	ing Physician: To the	best of my kn asis of examin ner stated.	owledge, o ation and/o	death occurred or investigation	at the time	e, date and inion, deatl	d place, and h occurred	due to the ca at the time, da	use(s) and ma te and place,	anner as stat and due to th	ed. ne cause(s	s)
	To the H within 24 To the Fi complete	Med	29b. Signature and title of certific	ier	. ^	\	29	c. License	number			d. Date signe	7 /		
	. ,,,		) ye	1 den		,	)	00	25	22	8	12/31	104		
			30. Name and address of perso	n who completed caus	e of death (Ite	m 23a) (Ty	(pe, Print)	/	11.1		DA	12/31 to, m	1 h	17/	
			31. Date filed (Month Day, Yea	ual, 11/2	26 egistrar's Sign	004	-iber	14/	4913.		Dal	to, on	0.d.	121	)
	Sta Regist	ate rar	31. Date filed (Month, Day, Yea	/	oyisirar s sign	S	Spon	las							

DHMH 17 Rev 1/2001

		State of Maryland / Department of Health and M  1 - State Registrar AMEND ITEM #26 PERPHY C838 12/13/04 JH  1. Decedent's Name (First, Middle, Last)	ental Hygie	2004	39386
Physici: /Medic		1. Decedent's Name (First, Middle, Last)  EMILY ANNA YOUNG		Day Year	3. Time of Death
Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMDRE		4c. County of Dea	J/A
Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Bir 105	thplace (State or Foreign ountry)
Maryland a-f show	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  MD N/A Baltimore			10d. Inside City Limits 1 ☑Yes 2 ☐ No
h with the 23e or 28	Funeral Director	10e. Street and Number 2913 Ellicott Drive 21216	10g.	Citizen of What C	
d 21215-UU36 filed within 72 hours after death with the Maryland Hyglene. ther than "neturel", or Items 23e or 28e-f show int, the Medical Francian menter califical at	by	11. Marital Status  1	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	
d KIKID-0030 filed within 72 hours af Hygiene. ther than "neturel", or the Wedfeel Errinint, the Wedfeel	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  SHA GYALL  16a. Decedent's Usual Occupation (Give kind of work done during most of working) (Ife. DO NOT use retired)  HOMEMAKER	ng 16b	DDMC	,
Maryland 2  In 2 Should be filed  Ith and Mental Hygi  Is marked other  treumatic event,	To Be Co	17. Father's Name (First, Middle, Last)  FRANK A. TRIPPS  SARAH  SARAH	(First, Middle, Mair	den Sumame)	
Hea the		cemetery, crematory or other place)	, BALTO	. MD 2 . Location - City or	Town, State
BAITIMOR permit. Pages Department of Important: If it eny injury or o		21. Signature of Emeral Service Lice 22. Name and Address of Facility VAUCHN C. FRENK 5151 BALTIMORE NA			
Pnysician /Medical		23a. Part1. Intenthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a	r respiratory arrest,		Approximate Interval Between Onset and Death Z d V
ate be executed by sician and the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (1820-2011) that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):			
o death certificate the attending physhed for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of de Month	livery Day Year
tuires that the signed by	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc		the cause of death?
II KECOLOS,  The law requires to the law been signed page 2 should be considered.	Completed		24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of
E ge Be	Certification; To Be	Matural 5   Pending (Month, Day Year)   Injury   Work?   2   Accident investigation   M   1   Yes 2   No	ne Jescribe how in	njury occurred	LIVING
i Diffig		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  29a. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, a	28f. Location (Street City or Town, St	tate)	
To the Hospitel within 24 hours a To the Funerel I completely filled	Medical	(Check only one)  2 ☐ Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.  29b. Signature and title of certifier  29c. License number	ed at the time, date	and place, and due	to the cause(s)
6		30 Name and address of person who completed cause of death (Item 23a) (Type, Print)	Balti	y rettel	2 21211
Sta Registr		31. Date filed (Month, Day, Year)  BFC 1 3 2004  32. Registrar's Signature  Aparks			

			1 - For State Registrar		aryland / Depa	artment of F			ene . No.2 11 11	20207
-	Physici /Medi	cal	1. Decedent's Name (First, Middle LEILA	DAINE	ALI			2. Date of Death Month		
	Examir	ier	4a. Facility Name (If not institution SHADY GROVE  5. Social Security Number	HOSPITAL	e (In yrs. last birthday)	ROCKVI			MONTGON	1ERY
	Funeral Director		None Usual Residence of Decedent 10a. State 10b. County	1□ M 2□ F	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, You	2004 Ma	thplace (State or Foreign ountry) ryland
, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examination to notified alongs.	To Be Completed by Funeral Director		ited   12. Was Decedent   Armed Forces?   1	N . Pot  Ever in U.S. 13.  No 16a. Dece- (Give life. N O	O m a C  101. Zip Code 208  Was Decedent of H If Yes, specify Cuba 1 Yes 2 No  dent's Usual Occup kind of work done of the Color NOT use retired n e	ispanic Origin? (St In, Mexican, Puerto Specify: ation during most of work 18. Mother's Nam S U S a	Decify Yes or No- Decify Yes or No- Decify Yes or No- Decify Yes or No-	ity or Town, State, .	erican Indian, te, etc. ite //Industry
Baltimore,	permit. Pages 1 a Department of Hes Important: If item any injury or othe		20a. Method of Disposition  1X Burial 2 Cremation  4 Donation 5 Other (S)  21. Signature of Funeral Service	pecify) Urensee W Mar	20b. Place of Dispo cematery, crer Geo. Wi	sition (Name of natory or other plac ash. Cen name and Addres 11 Kenn	net: 11- ss of Facility Un edy St,	29-04 iversal N.W., Was	E. Location - City or Adelphi II Mort hington	Town, State ,Maryland uary Inc.
8/60,	Physician /Medical Examiner	dicai Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list purchase if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Dum no out to for as a b. Due (or as a c.	a consequence of):  a consequence of):  a consequence of):			or respiratory arrest,		Approximate Interval Between Onset and Death  1 hr  1 hr  3 was  3 was
O. Box 6	death certific e attending p ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of dei Month	ivery Day Year
cords, P.	w requires that the de been signed by the a should be detached f	by	Part II. Other significant condition	shaly, hy	daps fitas	lis, ana	Sarca			the cause of death?
итан жес	The larate has	Se Completed	25. Was case referred to medical	, Social du	•	trainer of	Knew	24a. Was an autopsy performed 1 Yes 2 X	prior to death?	topsy findings available completion of cause of
VISION OT V	ding Phys h. After this funeral di	ertification: To B	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investig 3 Suicide 6 Could n	28a. Date of Injury (Month, Day pation	Year) Injury	28c. Injury Work M 1 🗀 Y	at ? (es 2 □ No	me 5 Residence 28d. Describe how in	njury occurred	
	h <sub>0</sub> 0 h	O	4 Homicide determi	building, etc	of my knowledge, death	Occurred at the tim	e date and place	28f. Location (Street City or Town, St	(ate)	stated
	To the Hospitel o within 24 hours aft To the Funerel Di completely filled in	Medical	29b. Signature and title of certifier  Williams  30. Name and address of person of	y Japollno who completed cause of de	teu.	29c. License	number	29d.	Date signed (Month	
	Sta Registr		A Kimberly II. 31. Date filed (Month, Day, Year) NOV 29	32. Registra	9901 Med r's Signature	Sparks	or Drive	. Kockvil	le, Mary	land 20850

			1 - For State Registrar	State of M	laryland /	-	artment rtificate			and M	lental H	giene Reg. No	$2 \cap \cap I$	. 3	93	88
	Physici	an .	1. Decedent's Name (First, Middle, La	e cher	Black		_			-	2. Date of D Month	eath Day	Yea	ır /	Time of	
	/Medic		4a. Facility Name (If not institution, giv	-		_	4b. City, T	Fown or	l ocation c	of Death	NOV	3.	County of De	-	0	
	Examin	er	Howard County Ge				•	Lumb		n Deali		10.	Howar			
	Funeral		5. Social Security Number 6. S	ex 7. A	ge (In yrs. last i	birthday)	If Under		If Under	24 Hrs. Min.	8. Date of B (Month, D	irth		Birthplace Country)	(State or	Foreign
L	Director		457.30.9288	☐M 21XTF	79	Yrs.	MOTUIS	Days	Hours		May 5,	192	5 Mc	Kinne	ey, [	Гехаs
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Lo	cation					-		10d. lr	nside Cit	y Limits
	Mary I-f sh	to	Maryland Howard		High	land								1	<b>∑</b> Yes	2 🗌 No
	th the	Director	10e. Street and Number				10f. Zip (	Code				10g. Citi	zen of What	Country?		
	23a c	ralD	7302 Mink Hollow	Road			20	777				U.	S.A.			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Dep. riment of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Examination to other traumatic event, it a Medical Examination to other traumatic event, it and the discrete for the injury or other traumatic event, it and the discrete for the injury or other traumatic event, it and the discrete for the injury or other traumatic event, it and it is a first for the injury or other traumatic event, it and it is a first for the injury or other traumatic event, it is injury or other traumatic event, it is injury or other traumatic event, it is injury or other traumatic event, it is injury or other traumatic event, it is injury or other traumatic event, it is injury or other traumatic event, it is injury or other traumatic event, it is injury or other traumatic event, it is injury or other traumatic event, it is injury or other traumatic event, it is injury or other traumatic event, it is injury or other traumatic event, it is injury or other traumatic event, it is injury or other traumatic event, it is injury or other traumatic event, it is injury or other traumatic event, it is injury or other traumatic event, it is injury or other traumatic event, it is injury or other traumatic event.	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates	? ]No	1	Was Decede fYes, speci 1 ☐ Yes 2			gin? (Spe , Puerto	ecify Yes or N Rican, etc.)		14. Race - Al Black, W Specify: V	hite, etc.	,	
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	Sta	te	31. Date filed (Month, Day, Year)	32 Regist	rar's Signature	1	1	1	-01U M	- 410-	1770	we (	77			
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State of Maryland / Department of Health and Mental Hygien 39389 Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) **Physician** November 15,2004 12:40am William Edward Bowers, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Chester River Manor Chestertown Kent If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Mar. 13, 1925 Birthplace (State or Foreign MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1**X** M 2□ F 79 Yrs. 218-20-6506 Director Usual Residence of Decedent 10c. City, Town or Location with the Maryland 10a State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-1 show any hjury or other treumatic event, the Marical Examination used by putflied at ODES. MD Rock Hall 1 XYes 2 □ No Kent Completed by Funeral Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21661 USA 5623 Circle Park Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 23 Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Transportation 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Reba Mae Joiner Thomas Lester Bowers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5632 Circle Park Drive, Rock Hall, MD 21661 Emily Bowers/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chester Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Nov.17,2004 Chestertown, MD <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
Fellows, Helfenbein & NEwnam, uk 130 Speer Road, Chestertown, MD 21620 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or com-shock, or heart failure. List only ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Immediate Cause (Final onemama Physician disease or condition resulting in death) /Medical Due to for as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (De ause of highly that initiated events Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit iding physician and resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medlcai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ed by the atten-3 Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has certificate 1 ☐ Yes 25. Was case referred to medical examine? 26. Place of Death (Check only one) Be 2 No Certification: To 1 TYes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral dir 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation after death.

Director: A in by the fu 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 MD 0051786 use of death (Item 23a) (Type, Print) 30. Name and address of person who completed of MD 1900 Terqu 32. Registar's Signature 31. Date filed (Month, Day, Year) State 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 0 0 4

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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if them 27 is marked other than "neturel; or items 23a or 28e-1 show eny injury or other traumatic event, the Mucilcal Examinat must be notified at once.		21. Signature of Funeral Service Licent	-	TTL	-	Memorial Name and Address			2004 W	aldori	, MD		
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0	ng Ph ter th		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	y Year) 2	28b. Time of Injury	28c. Injury Work			Describe how				
0	endir eath. or; Al	atlc	2 Accident investigation			,		es 2□N	lo					
Division of	or Att	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	iry - At hom :. (Specify)	ne, farm, stre	et, factory, office			Location (Stree City or Town, S		ber or Rural	Route Number,	
	ortal o			1										, W
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funerel Director; After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying Physical Check only onel	sicien: To the best oner: On the basis of	examinatio	ledge, death on and/or inv	occurred at the time estigation, in my opi	e, date and nion, death	l place, and on n occurred at	due to the caus t the time, date	se(s) and ma and place,	anner as sta and due to	ted. the cause(s)	
	ithin ithin or the control	Med	29b. Signature and title of certifier	and manner stat	180.		29c. License	number		29d	Date signe	ed (Month. D	lav. Year)	
	⊢ ≱ <del>-</del> ŏ		Pente MO					33	46	_50	1116	291	2004	
			30. Name and address of person who co	mpleted cause of de	ath (Item 9	23a) (Type F	Print)					. /	1	
ļ	5			ND 890	26 v	(100c	YARD RI	OAD.	#20	1. 41	NON	MD	20733	5
ì	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	S Signatu	re .	Sparles							
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		Ce	ertificate of De	ath	Reg. N	12. U U 4 10.	39392
Dhysisian	1. Decedent's Name (First, Middle, Last)				Date of Death		3. Time of Death
Physician /Medical	LINDA KAY CON					2004	1958
Examiner	4a Facility Name (If not institution, give street a		4b. C	City, Town, or Location	on of Death	c. County of Death	
	5. Social Security Number 6. Sex	Hospital 7. Age (In yrs. last birthda)	v) If Under 1 Year   If	Berlin Under 24 Hrs.   8. [	Date of Dirth	Worcest	
Funeral Director	526-68-4628  Usual Residence of Decedent	59 Yrs.		lours Min. (	Date of Birth Month, Day, Yea B / 14 / 194		place (State or Foreign ntry) regon
// // // // // // // // // // // // //	10a. State 10b. County	10c. City, Town or I	Location			1	Od. Inside City Limits
e Ma Ba-f s	MD Worcester	Berlin	1				<b>X</b> es 2 □ No
958 th with the Main the Main the Main the Main the motified was be notified ail Director	10e. Street and Number		10f. Zip Code		_	Citizen of What Cour	ntry?
ath wath wath warm	9939 Orchard RI		21811			JSA	
L+M0A   958 TO and 21215-0020  be filled within 72 hours after death with the Maryland tall Hygiene. d other than 'natural', or items 23a or 28a-f show event, the Medical Examinat must be notified at Be Completed by Funeral Director	1 Never Married 2 Married	Decedent Ever in U,S. ad Forces? Yes 2 No s, Give 1972-76 or Dates:	. Was Decedent of Hispar If Yes, specify Cuban, M 1 ☐ Yes <b>X</b> ☐ No Sp		Yes or No- n, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
22 hg	15. Decedent's Education (Specify only highest grade comple	16e. Dec	edent's Usual Occupation	n a most of working	16b.	Kind of Business/Ind	dustry
LNDA 63 8 121215-0 led within 72 ho led within "naturi for then "naturi it, the Medical.		ege (1-4or 5+)	e kind of work done durin DO NOT use retired)			0	
d 212 d 212	17. Father's Name (First, Middle, Last)	3 R		Nurse Mother's Name (Fire		ealth Car	e
ylanc ylanc ould be fi Mental H Mental H arked oth	Norman Eugene Wo	orthley		Jeanne W		•	
TAN SEE	19a. Informant's Name/Relationship (Type, Prin		ling Address (Street and I				Code)
N P P P P P P P P P P P P P P P P P P P	Erin Conner		9 Orchard			21811	0000,
€ € £ 2	20a. Method of Disposition	20b. Place of Disp		Da	te 20c. I	Location - City or To	wn, State
imor imor Pages nent of nut: If Ik	1 ☐ Burial 2 ☐ remation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	from State	enlopen Cre	matory	7/04 Fr	ankford,	DE
Sch Saltimore, Baltimore, pemit. Pages 1 ar Department of the minorant: If them; any injury or other once.	21. Signature of Funeral Service Licensee		22. Name and Address of	Facility Bur	baga Er	inoral Ho	mo
N BEEEB	Tappiegling 1	Mallorti	108 William	St. Berli	n MD	21811	me
THE PERSON	27a. Part1. Enter the dilease, or complications shock, or heart as ure. List only ause		Approximate Interval Between				
SH4/8 Physician			,			]	Onset and Death
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	ulmonory c	mbolism				
2	resulting in death)	Due to (or as a conse	equence of):				-
D, executed in and nal-transit	b						
sxecu n and al-tra	Sequentially list conditions, if eny, leading to immediate	Due to (or as e conse	equence of):			1	
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68 tifficat as th as th	resulting in death) Last	Due to (or as a conse	querice or).			!	
Box ( Bath certi Bath certi attending for use a	d						
• 0 0 2	Part II. Other significant conditions contributing	to death but not resulting in the	underlying cause given in	Part I.	23b. Dld tobacc	o use contribute to	the cause of death?
P.O lat the d by the etache					1 🗆 Yes	2 No 3 □ Prob	ably 4 Unknown
ords, P.O. Boy requires that the death or een signed by the attend hould be detached for us				-			
OF requirements of the control of th				2	24a. Was an auto performed?	ava	re autopsy findings hilable prior to inpletion of cause
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Vital Recsion: The law contilicate has to director, page 2 so be Comple	05 M				1 ☐ Yes 2	10	Yes 2 No
of Vita Physician: This certific ral director,	25. Was case referred to medical examiner?  1 Yes/ 2 No  Hospital:	1 Minpatient 2 ☐ ER/Outpatie	Other:	Place of Death (Che		A [[0]]	
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Vision Attending Is reach. Sector: After by the funer Iffication	1 Natural 5 Pending 2 Accident investigation	Month, Day Year) Injury	M 1 ☐ Yes	2 □ No			
Division ( tal or Attending P ts after death. al Director: After t led in by the funer; Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 28e.	Place of Injury - At home, farm, st uilding, etc. (Specify)	treet, factory, office		ocation (Street a.	nd Number or Rural	Route Number,
Cert Cert		(oposij)			, c. romi, olai		
Division of Vital Re To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	(Check only 2 Medical Examiner: On t	o the best of my knowledge, deat ne basis of examination and/or in manner stated.	th occurred at the time, da evestigation, in my opinion	ate and place, and do n, death occurred at	ue to the cause(s the time, date an	s) end manner as sta od place, and due to	ated. the cause(s)
To the within To the comp	29b. Signature and title of certifier		29c. License num		29d. Da	ate signed (Month, E	Jay, Year)
	/ Che mo		D5361	2	12	15/04	
	30. Name and address of person who completed	cause of death (Item 23a) (Type	Print)	0	10	01311	
	Andrea & Bajer	4755 Healt	hway 120	Derlin,	mo.	21011	
State Registrar	31. Date filed (Month, Day, Year) DEC 1 3 2004	2. Registrar's Signature		/			

DHMH 16 Rev 6/95

Amended #26, 11/19/04, cwc Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 1 Kent Co. 39393 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 15, Month **Physician** November 2004 13:16 Barbara Ann Clough /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chester River Hospital Center Chestertown Kent If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Feb. 20, 1955 Birthplace (State or Foreign PA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2∰F 49 yrs. 080-46-9803 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Innportant: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other tranmatic avant, it is Medical Exist at we make the modified as 1X Yes 2 No MD Millington Director Kent 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10264 Big Stone Road 21651 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 █️No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Gilbert Zucchi Winifred Marone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Clough Sr./Husband 10264 Big Stone Road, Millington, MD 21651 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Crumpton Cemetery Nov. 19, 2004 Crumpton, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral Service Licensee 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, MD 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PULHONARY /Medical **Examiner** Myocardial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to (or as a consequence of) sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, OBesity, 1 Yes 2 No 3 Probably 4 Unknown Respiratory Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Neurological Sesense Restricted but to 2 No 1 ☐ Yes 2 ☐ No 1 🗌 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death After 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be 3 🗌 Suicide within 24 hours after de To the Funeral Directo completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vohne. ARRABAL M. M. D, 223 It flistest CHEStentown 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar
DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Mar	yland / Dep	artment of H	lealth and N	Mental Hygie	ene	0000		
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	/Medio Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death		4c. County of Death			
м			Manor Care-Bethe	sda		Bethes	da		Montgome	erv		
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	land ow		10a. State 10b. County	1	Oc. City, Town or L	ocation	<del></del>			10d. Inside City Lin		
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	deat ma	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent of H	lispanic Origin? (Sp	pecify Yes or No-	14. Race - Amer			
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	10	1	30. Name and address of person who o	completed cause of deal	th (Item 23a) (Type			N	ovember 26	, 2004		
			Narita Surana, M.			*	Road. O	lney, MD	20832			
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				artment of Health and Mertificate of Death	ental Hygie	2001	30205
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
8	/Medic		MARIAN CHANDLER		NOVEMBER		7:10 P M
	Examin	er	4a. Facility Name (If not institution, give street and number) FREDERICK MEMORIAL HOSPITAL	4b. City, Town, or Location of Death FREDERICK		4c. County of Death FREDERICK	
	Funeral		Social Security Number     6. Sex     7. Age (In yrs. last birthday)	) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthp	lace (State or Foreign
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	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation			Od. Inside City Limits
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o		- To	27. Many of Death 28a. Date of Injury 28b. Time of	The second second	e 5 Residence 3d. Describe how in		)
o	ath. r: After e funer	atlor	1 Matural 5 Pending (Month, Day Year) Injury 2 Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
<u>×</u>	I or Attendate death Director:	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stream building, etc. (Specify)	reet, factory, office	Bf. Location (Street: City or Town, Sta	and Number or Rural	Route Number,
	Hospital o		200 Codilios 4 Continuing Physician T				
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one)  1   Certifying Physicien: To the best of my knowledge, deat 2   Medical Exeminer: On the basis of examination and/or in and manner stated.	n occurred at the time, date and place, ar vestigation, in my opinion, death occurred	d at the time, date a	(s) and manner as stand due to	the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	29d. D	Date signed (Month, E	Pay, Year)
	1		· Collumn Aludu M	40061487	/	11/26/	04
	>		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)			
	- Ch		Colleen Mary Sluder, M.D., 400 W 7t  31. Date filed (Month, Day, Year) 32_Registrar's Signature	h Street, Frederic	k, Maryla	nd 21701	
*	Sta Registra		NOV 2 9 2004 5	Sparks			

			State Registrar	f Maryland / Depa	artment of Health and rtificate of Death	•	
	Physic /Medi Examir	cal	Decedent's Name (First, Middle, Last)     JOHN CARROLL CLOUGH      4a. Facility Name (If not institution, give street and number of the control of the	mber)	4b. City, Town, or Location of Deal	NOVEMBER	
	Funeral	ier	CORSICA HILLS NURSING 1 5. Social Security Number 6. Sex	HOME 7. Age (In yrs. last birthday)	CENTREVILLE If Under 1 Year If Under 24 Hrs	· 8. Date of Birth	4c. County of Death  QUEEN ANNE S  9. Birthplace (State or Foreign Country)
	Director		213-16-8674	86 Yrs.	Months Days Hours Min.	JAN. 11,	1918 MARYLAND  10d. Inside City Limits
	th the Mary or 28a-f sh	irector	MD QUEEN ANNE 's	CHURCH	HILL 10f. Zip Code	10g. (	1 ☐ Yes 2 💆 No
36	s 1 and 2 should be filed within 72 hours after death with the Maryland If Health and Mental Hygiene. If Health and Mental Hygiene. If Item 27 is marked other then "neturel", or Items 23s or 28s-f show other treumatic event, the Medical Estrington must be inclined at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☑ Yes If Yes, Gi	2 □ No /e	21623  Was Decedent of Hispanic Origin? (Singles, specify Cuban, Mexican, Puer		SA  14. Race - American Indian, Black, White, etc.  Specify: WHITE
21215-0036	ithin 72 hours ne. hen "neturel", e Medical Ex	Completed b	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  1 1	16a. Decec (Give iffe. L	lent's Usual Occupation kind of work done during most of wo OO NOT use retired)	rking	Kind of Business/Industry
Maryland 2	should be filed and Mental Hygie marked other umatic event, II	To Be Co	17. Father's Name (First, Middle, Last)  E. SCOTT CLOUGH		ELIZAI	ne <i>(First, Middle, Maide</i> BETH LEAGER	
	s 1 and 2 sho of Health and item 27 is my other treums		19a. Informant's Name/Relationship (Type, Print) FRANKLIN C. CLOUGH/SON  20a. Method of Disposition	19b. Mailin 8 STE	g Address (Street and Number or Ru VENS LANE, P.O. I	30X 185, CR	UMPTON, MD 21628
altimore,	nit. Page artment o ortant: If injury or e.		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from  1 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee   /	State CHESAPEAK	eatory or other place) NOV E CREMATION 2	16, 2004 STE	VENSVILLE, MD
Ä	Dep Imp	7. 1	23a. Part1. Enter the disease, or complications that c shock, or heart failure. List only one cause on e	aused the death. Do not ente	LLOWS, HELFENBEIN OF SPEER ROAD CHES or the mode of dying, such as cardiac	& newnam TERTOWN, M	FUNERAL HOME, P.A. D 21620  Approximate
	death certificate be executed XX  Executed the property of the principle o	ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  a. Due to (  Due to	or as a consequence of):  or as a consequence of):	S (Gastroespo	nonig	Interval Between Onset and Death 2 week.
P.O. Box 6	that the death certifica ed by the attending ph detached for use as th	Physician/Med	in the past 12 months?	ant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
	law requires that the as been signed by the 2 should be detache	٩	Part II. Other significant conditions contributing to de	US	derlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
al Reco	the ate h page	Completed	Ostrevarthuit	is other	-15	24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ W	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No
Division of Vital Records,	id is	ToB	25. Was case referred to medical examiner?  1	patient 2 ☐ ER/Outpatient f Injury , Day Year)  Z8b. Time of Injury	04	th (Check only one) ome 5 Residence 28d. Describe how inju	
DIVIS	rial or Auc	Certification:		of Injury - At home, farm, stre g, etc. <i>(Specify)</i>		City or Town, Stat	
:	within 24 hours a To the Funerel Completely filled	Medicai	one) and mann	sis of examination and/or inve	occurred at the time, date and place, estigation, in my opinion, death occur	and due to the cause(s red at the time, date an	s) and manner as stated. d place, and due to the cause(s)
3	V Wit		29b. Signature and title of certifier  **Lussell G - Su  30. Name and address of person who completed cause	of do at (the - 00a) (T - 0	29c. License number 442 - 87	111	ite signed (Month, Day, Year)
	Stat Registra	te	Russell A Schillen de	of death (Item 23a) (Type, P	nwood & Ea	stan und	21601

DHMH 17 Rev 1/2001

1. December Name (First, Mostles, Last)   Carry   Wayne   Gross   2.0 but of Dates   Accounty of Dates				1 - For State Registrer	State of Maryl		artment of H			2004	39397
## Further Fundamental Prince of the control in State College of Calivort Exemption (Calivort Exemption Calivort on Calibration C		Dii-i		1. Decedent's Name (First, Middle, Last	)				2. Date of Death		3. Time of Death
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Social Social Process   The		Examin	er								
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The state of the control of the co				, t-G	7 M 2□F	Vec	Months Days	Hours Min.	(Month, Day, Y		
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Glenn Arthur Gross  Glenn Arthur Gross  Glenn Arthur Gross  Jeannie Paulline Walthall  Janette Gross, wife  1198. Mailing Address (Sreat and Number or Must Route Numbers, City or Town, State, 26 Code)  Janette Gross, wife  1200. Walthord of Disposition  Janette Gross, wife  1199. Mailing Address (Sreat and Number or Must Route Numbers, City or Town, State, 26 Code)  Janette Gross, wife  1200. Walthord of Disposition  Janette Gross, wife  1200. Walthord of Disposition  Janette Gross, wife  1200. Walthord of Disposition  Janette Gross, wife  1200. Walthord of Disposition  Janette Gross, wife  1200. Walthord of Disposition  Janette Gross, wife  1200. Walthord of Disposition  Janette Gross, wife  1200. Walthord of Disposition  Janette Gross, wife  1200. Walthord of Disposition  Janette Gross, wife  1200. Walthord of Disposition  Janette Gross, wife  1200. Walthord of Disposition  Janette Gross, wife  1200. Walthord of Disposition  Janette Gross, wife  1200. Walthord of Disposition  Janette Gross, wife  1200. Walthord of Disposition  Janette Gross, wife  1200. Walthord of Disposition  Janette Gross, wife  1200. Walthord of Disposition  Janette Gross, wife  1200. Walthord of Disposition  Janette Gross, wife  1200. Walthord of Disposition  Janette Gross, wife  1200. Walthord of Disposition  Janette Gross, wife  1200. Was december progrant  Janette Gross, wife  1200. Was december progrant  Janette Gross, wife  1200. Was december progrant  Janette Gross, wife  1200. Was december progrant  Janette Gross, wife  1200. Was december progrant  Janette Gross, wife  1200. Was december progrant  Janette Gross, wife  1200. Was december progrant  Janette Gross, wife  Janette Gross, wife  Janette Gross, wife  Janette Gross, wife  Janette Gross, wife  Janette Gross, wife  Janette Gross, wife  Janette Gross, wife  Janette Gross, wife  Janette Gross, wife  Janette Gross, wife  Janette Gross, wife  Janette Gross, wife  Janette Gross, wife  Janette Gross, wife  Janette Gross, wife  Janette Gross, wife  Janette Gross, wife  Janette Gross	36	s afte	y Fu		1 ☐ Yes 2 No If Yes, Give	1					
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Spoop of the composition of completion of contribute to the cause of death?    1	ŏ	th cert endin	an/M	23b. Was decedent pregnant			Ectopic pregnancy				•
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24a. Was an autopsy performed?  25. Was case referred to medical examiner?  1	Д.	that the	Phy		ntributing to death but not	resulting in the ur	deriving cause give	n in Part I	23e Did tobac	co use contribute to t	he cause of death?
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29a. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Mopth, Day, Year)  29d. Date signed (Mopth, Day, Year)  29d. Date signed (Mopth, Day, Year)  29d. Date signed (Mopth, Day, Year)	S U	ting P	ion:	1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Time of Injury			28d. Describe how	injury occurred	
29a. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Mopth, Day, Year)  29d. Date signed (Mopth, Day, Year)  29d. Date signed (Mopth, Day, Year)  29d. Date signed (Mopth, Day, Year)	ISI(	Attende death ctor: y the	ficat	3 Suicide 6 Could not be	28e. Place of Injury - A	t home, farm, stre			28f. Location (Stree	nt and Number or Run	al Route Number.
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Charles A Tudge M. D. 110. Hermited B. D. 1210. Points B. D. 1210.		Hospit 24 hour Funere tely fille		(Check only 2 Medical Exami	ner: On the basis of exam	nowledge, death	occurred at the time restigation, in my opi	e, date and place, inion, death occur	and due to the caus red at the time, date	e(s) and manner as s and place, and due to	tated. o the cause(s)
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Charles A Judge M.D. 110 Heavited Dd. #210 Date D. J. J. D. Co. Charles Dd. #210 Date	<b>L</b>			1			059	65)		17/24/4	
Charles A. Judge, M.D., 110 Hospital Rd. #310, Prince Frederick, MD 20678  State Registrar  NOV 2, 9 2004)  State Registrar  Registrar  Signature		10			,		,		1		
Registrar NOV 2. 9 2004) Kleen & Specific		1	•	Charles A. Judge, 31, Date filed (Month. Dav. Year)	M.D., 110 H	ospital	Rd. #310,	Prince	Frederick	, MD 20678	3
			ar	NOV 2	9 2004) See	w B.	Sperke	!			

			1 - For State Registrar	State of M	1arylan	d / Depa	artment of H	ealth ai Death	nd Mer	ntal Hygie	ene 0 (	)4	393	98
			1. Decedent's Name (First, Middle, L.	ast)						Date of Death Month	Day	Year	3. Time of D	Death
	Physicia /Medic		John L. Currie	r, Jr.					,	ovember			3:58	PM
1	Examin	er	4a. Facility Name (If not institution, gi				4b. City, Town, or				4c. County			
			Anne Arundel Me			In a d faireth of a cold	If Under 1 Year	nnapo		Data of Dist	Anne	Aru		
	Funeral Director		5. Social Security Number 6. 218–32–9862	Sex 7.A 1 <b>½</b> M 2 □ F	.ge ( <i>in yr</i> s. 68	last birthday) Yrs.	Months Days	Hours	Min.	Date of Birth (Month, Day, Y	1936	Cour		Foreign
			Usual Residence of Decedent							ct. 11,	1930	Mal	yland	
	nylan show		10a. State 10b. County		10c. Cit	y, Town or Lo						1	0d. Inside City	
	8e-fs	cto	*	Arundel				polis					1 XYes 2	2   No
	within 72 hours after death with the Maryland ene. Than "naturel", or Itams 23a or 28e-f show re Majical Examirer must be notitled at	Funeral Director	10e. Street and Number 310 McDonough Ro				10f. Zip Code	2140	1	10g	. Citizen of V	Vhat Cour	ntry?	
	eath	erai	11. Marital Status	12. Was Deceden	t Ever in U	S. 13.V	Vas Decedent of Hi			Yes or No-			an Indian,	
ഗ	or Itan	Fun	1 Never Married 20 Married	Armed Forces	?		f Yes, specify Cubai	n, Mexican,	Puerto Rica	an, etc.)	Blac	k, White,	etc.	
21215-0036	ref', o	l by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	:		l□Yes 2XXXNo	Specify:			Specify	· Wh:	ite	
5-(	72 h "natu	Completed	15. Decedent's £ (Specify only highest g.			(Give	lent's Usual Occupa kind of work done d	lurina most c	of working	16	b. Kind of Bu	usiness/Ind	dustry	
12	withir ane. than	duo	Elementary/Secondary (0-12)  College (1-4or 5+)  4  College (1-4or 5+)  Manager/Technical Services									Tnd	ustry	
0 0	filed Hygi other ent, I	Be Cc	17. Father's Name (First, Middle, Las			120.209	01,100.11		-	rst, Middle, Ma			ab cr 1	
Baltimore, Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Healin and Menth Hygiens. It if item 27 is marked other than "naturel; or items 23a or 28e-1 show it it is marked other than "naturel; or item 27 is marked other transmit."	To B	John L. Currier	zabeti	h V. Me	yett								
lan	2 sho and h is ma		19a. Informant's Name/Relationship				g Address (Street a						Code)	10
≥, ≤	and lealth m 27 her tr		Suzanne Currier	/wife	00h F		cDonough	Road		∞lis,			21401	
0	ges 1 It of H If ite or oth		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3		в С	emetery, cren	sition (Name of natory or other place	' L	Date		c. Location -			
텵	it. Pa intmen intent: njury		'4 □Donation 5 □ Other (Spec		St.	~ -	s Cemeter			2004 A				nd
Ba	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tre once.		Joda (	E . Tu	We		Name and Addres  Name of							101
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that cause y one cause on each	ed the deat line.				,	-			Approximate Interval Betwee Onset and De	en eath
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Athe	nusci		re Can	dio V	asc.	DI'S.				
	Examiner			Due to (or a	s a conseq	uence of):								
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8760,	death certificate be executed e attending physician and ad for use as the burial-transit	dicai	-= =	d										
9 x 6	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregna	incy					23d Date	e of delive	nv.	
Вох	death d for u	iciar	in the past 12 months?	1□Live birth 4□Pregnant			Ectopic pregna <i>ncy</i> Other (s <i>pecify</i> )				Mor		Day Ye	ar
P.0	that the deed by the a	hys	9 Unknown	9□ Unknown										
	es De	by	Part II. Other significant conditions	contributing to death	but not res	ulting in the ur	nderlying cause give	n in Part I.		23e. Did tobac	- "			
Records,	w requir been si should	Completed							_	1 🗆 Yes			ably 4 □Un	
3ec	has b	mpie								24a. Was an autopsy performer	d2 P	Vere autor prior to con leath?	psy findings av npletion of cau	allable ise of
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Vital	Physicien: rthis certific ral director,	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	iont 0	ER/Outpatien	Othe	r		heck only one)	- 0 000	/0 1		9
o	g Phy er this	n: To	27. Manner of Death	28a. Date of Inj	ury	28b. Time of	28c. Injury Work		-	5 Residence Describe how			"	_
lon	Attending r death. ector: After by the fune	atio	Natural 5 Pending Accident investigation	(Month, D	ay rear)	lnjury		? ′es 2 □ No	0					
Division of	r Atte	Certification:	3 Suicide 6 Could not determined	4   289. Place of I/	njury - At ho	ome, farm, stre	eet, factory, office		28f.	Location (Stree City or Town, S	et and Numbe State)	er or Rura	Route Numbe	9 <i>r</i> ,
	oltel o urs af arel D													
	To the Hospitel or Attending Physicien: within 24 hours after deals. To the Funerel Director, After this certific completely filled in by the funeral director,	edical	29a. Certifier (Check only one)  Certifying P  2 Medical Exa	hysicien: To the bes miner: On the basis and manners	of examina	wledge, death tion and/or inv	occurred at the tim restigation, in my op	e, date and inion, death	place, and occurred a	due to the caus it the time, date	e(s) and mai and place, a	nner as stand due to	ated. the cause(s)	
	To ti Withi To ti comp	Ň	29b. Signature and title of certifier	a.		/m/	29c. License				Date signed			
)			Mario	7 / Von	w	1 101/1	100	5202	23		11/	23	104	
			30. Name and address of person who	completed cause of	death (Item	23a) (Type,	Print) ease this	hoay	Six	e112,	mna	poli	s, Mo	e
	Sta Registr	1.25	31. Date filed (Month, Day, Year) NOV 24		trar's Signa	ture	Soul	-0				210	101	

			1 - State Registrar	State of Marylan		artment of F rtificate of		Mental H	ygiene Reg. No. 200	4 39399		
	Physic /Medi	cal	Decedent's Name (First, Middle, Lasi     Earl Davis     Aa. Facility Name (If not institution, give)			4b. City, Town, o	r Location of Do	2. Date of D Month Novemb	Day Ye	3. Time of Death 3:40 PM		
	Examin Funeral Director	ner	1202 Alhambra Ave. 5. Social Security Number 6. Se	•	last birthday) Yrs.	ACCOKE  If Under 1 Year  Months Days	ek	rs. 8. Date of B	Prince	George's Birthplace (State or Foreign Country) shington DC		
	within 72 hours after death with the Maryland ene. thsn "naturel", or items 23a or 28a-f show the Mudical Exemple must be nothined at	Funerai Director	10a. State 10b. County  Maryland Prince Ge 10e. Street and Number	eorge's Acc	y, Town or Lo	10f. Zip Code			10g. Citizen of What	•		
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryla f Heelth and Mental Hygiene. Item 27 is marked other than *naturel', or Items 23a or 28a-f show ther treumatic event, the Modical Examinating the routified at	by	1202 Alhambra Ave.  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		20607. Was Decedent of H If Yes, specify Cuba	Specify:	(Specify Yes or N erto Rican, etc.)	Specify:	American Indian, White, etc. White		
2121	filed within 72 Hygiene. Ither then *nater, it is Mydle	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation te completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired Dopera	during most of w	rorking	Painti			
Maryland	2 should be fill and Mental Hy Is marked oth eumatic event	To Be	17. Father's Name (First, Middle, Last)  George Emory Davis  19a. Informant's Name/Relationship (7)		19b. Mailir	ng Address (Street	Annie	Mae Hea	e, Maiden Sumame)  y  ber, City or Town, Stat	e Zin Code)		
	0 0		Cathy Davis-Blanke  20a. Method of Disposition  1 XBurial 2 Cremation 3	enbaker  20b. P	1202_ lace of Dispo emetery, cren	Alhambra sition (Name of natory or other place	Ave., A	Accokeek Date	MD 20607 20c. Location - City	or Town, State		
Baltimore,	permit. Page Department Importent: If eny Injury or once.	Trinity Mem. Gardens 11-29-2004 Waldorf, Ma  21. Signature of Funeral Service Licensee M00053  M00053										
	Physician		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition	ne cause on each line.	i. Do not ent	er the mode of dyin	g, such as cardi	ac or respiratory	arrest,	Approximate Interval Between Onset and Death		
100	/Medical Examiner		resulting in death)	a. MULTI INFARC Due to (or as a consequ	uence or):					MONTHS		
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State of Maryland / Department of Health and Mental Hygic

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	Examiner	4a Fecility Neme (If not institution, give				4b. City, Town, o	r Location of Death	4c. County	of Death		
ſ		Prince George's Ho	spital Cente	er		Cheverly		Prince	e Geor	rge's	
	Funeral Director	5. Sociel Security Number 6. Sociel Security Number 577-76-0748	9x 7. Age (in y 12x M 2□ F 77	rs. lest birthde Yrs.	Months De	ear If Under 24 Hi eys Hours Mil		1927 , <sub>Year)</sub> :r 5	9. Birthpl Count Guyar	ece (State or Foreig ry) 12	n
	and and	10e. State 10b. County	10c.	City, Town or	Location				10	d. Inside City Limits	
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Maryland 21215-0020	ors by	3 ☐ Widowed 4 ဩ Divorced	1 Tyes 2 No If Yes, Give Yeer or Dates:		1 ☐ Yes 23☑		nto riidaii, etc.)	Specif	ck, White, e y: B1a		
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Ball	permit. Departr Importa any Inji	21. Signature of Funeral Service/Licen	see j			ndover Roa	J.B. Jenk Id Landove				
	E.	23a. Part 1. Enter the disease, or comp shock, or heart taiture. List only	ticetions that caused the done cause on each line.	eath. Do not e	nter the mode of	dying, such as cardi	ac or respiratory arm	est,	1	Approximate Intervat Between	
	Physician Wedical Examiner	tmmediate Cause (Final disease or condition resulting in death)	a. SHOK B	IN H	A CATT	0 N			1	Onset and Death	
ox 68760,	eath certificate be axecuted attending physician and for use as the burial-transit clan/Medical Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c	o (or as a conse							
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Division	P # F F	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, ferm, s ocify)	street, factory, off	ice	28f. Location (Si City or Town 12056	reet end Numb n, S. te) REE LE	er or Rurel YRD	Route Number.	Z/
	Hospi 14 hou Funer tely fill		rsician: To the best of my liner: On the basis of exam and manner stated.								
	To the within 2 To the compla	29b. Signature and title of certifier			29c. Lic	ense number ME	I	9d. Date signe Novembo			
(i)	P (2)	30. Name end address of person who o									
	State	31. Dete filed (Month, Day, Year)	B10, RD		1 Penn	Street, Ba	altimore,	Maryla	nd 21	201	_
-51	Registrar	NOV 2 9 2004	Ke b	v 1	- m						

State Registrar 31. Date filed (Month Cay Year)

ANA

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RUBIO, MD

111 PENN STREET, BALTIMNORE, MARYLAND 21201

			State of Maryland / Department of Health a  1 - State of Maryland / Department of Health a  Certificate of Death		giene 004	39402
	Physic	ian	Decedent's Name (First, Middle, Last)	2. Date of Dea Month	th Day Year	3. Time of Death
	/Medi Exami		4a. Facility Name (If not institution, give street and number)  NATIONAL NAVAL MEDICAL CENTER  4b. City, Town, or Location of BETHESDA		4c. County of Death MONTGOM	2:22
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 1 Months Days Hours Usual Residence of Decedent	8. Date of Birth (Month, Day)	Year) Cour	olace (State or Foreign htry) IZONA
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Initry or other traumatic event, the Medical Examination to the rotified at once.	To Be Completed by Funeral Director	149 EAST VOLTAIRE ST.  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin (If Yes, specify Cuban, Mexican, 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	of working  LAUREN For Rural Route Number,  ST., PHOENI Date  EC.3,2004	Og. Citizen of What Cour  U.S.A  14. Race - Americ Black, White, Specify: WHI  16b. Kind of Business/Inc  DEFENSE Maiden Sumame) EILER City or Town, State, Zip  EX, AZ. 8502 20c. Location - City or To  PHOENIX, AR	Code) L2 wn, State
al Records, P.O. Box 68760,	ician: The law requires that the death certificate be executed EXECUTED TO SET IN THE CONTINUE OF THE PROPERTY	Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown   9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   5   Other (specify)   9   Unknown   9   Unknown   9   Unknown   9   Unknown   Part II.	MEN  23e. Did tob 1  Ye  24a. Was ar autops, perform	23d. Date of delivered Month  acco use contribute to the second 24b. Were autopyrior to contribute?	Day Year
Division of Vital	Hospital or Attanding Phys 4 hours after death. Funaral Director: After this ely filled in by the funeral dii	edical Certification; To Be	examiner?	28d. Describe hor  CO  28f. Location (Str. City or Town, U)	nce 6 □Other (Specify, w injury occurred  MBAT  eet and Number or Rural State)  NKNOWN	Route Number,
	qt		29b. Signature and title of chitis  30. Name and address of person who completed cause of death (Ipem 23a) (Type, Print)  ARMED FORC  MICHAEL E SMITH MAJ MC USA  31. Date filed (Month, Day, Year)  32. Begistrar's Signature	// 33 A	d. Date signed (Month, D	2004
	Sta Registr	.0 4	NOV 29 2004 Janua & Sparks			

State of Maryland / Department of Health and Mental Hygien 39403 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month COL **Physician** DAMIAN Day S. 1958 CAUS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MONTGOMBRY GENTRAL HOSAMAL MONTGOMBIA OLNE7 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ₩ 2 □ F Director 220.02.7865 26 March 6, 1978 Jamaica, W.I. Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28e-f show The Medical Exercitors must be notified at Director 1 Ves 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ Items 23a 14211 Parker Farm Way 20906 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced "natural" **Black** Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) filed withi Hygiene. Retail 12th <u>Salesperson</u> other other traumatic event, 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be flik Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Sumame) Be Victor George Davis, Sr. Enid E. Reid 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) George Wash. Cemetery 11/21/2004 Adelphi, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME 11800 New Hampshire Ave. Silver Spring, MD 20904 23a. Part1. Enter the closese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) Onset and Death Pnysician ASPHAXIA /Medical Due to (or as a consequence of) Examiner STRANGULATIN E BRA Sequentially list conditions, if any, leading to immediate cause (Disease or injury Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed 201010E that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Cher (specify) P.O. ed by the a detached f 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by CES NEXIO 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 X No 1 Yes 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ★EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending MACO 1 ☐ Yes 2 No HAWGING - SUICIOF within 24 hours after death. To the Funeral Director: A 15/04 investigation 2 Accident 6 Could not be determined 3 Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 14211 PANCETHIM WILT HOME Siver spake, 40 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) (OME) Novement 15, 2004 1915236 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UNT ROCKERES 8/KG, locaine, NO 20857 (Due) CHARL I. MARGOLKIMS 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 29 2004 oorka Registrar

State of Maryland / Department of Health and Mental Hygiene 004 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** November 23, 2004 Duckett 4:15 P Crystal /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges 15169 Regina Avenue Brandywine If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) February 15,1959 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M ZOXF **Director** 219-72-6504 45 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location item 27 is marked other then "natural", or items 23a or 28a-f show other treumetic event, the Madical Examinar must be notified at 10d. Inside City Limits Director 1X Yes 2 No Brandywine Maryland Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15169 Regina Avenue 20613 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 🕱 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) Genesis Nursing Home Nursing Assistant 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit Pages 1 and 2 should be Department of Health and Mental Importent; If Item 27 Is marked o Matilda Gray Duckett F. Duckett. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Matilda Duckett/Mother 15169 Regina Avenue Brandywine, Maryland 20613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
'4 ☐ Donation 5 ☐ Other (Specify) Trinity Memorial Gar. 12/1/04 Waldorf, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility any ir once. dessa MO1323 Adams Funeral Home P.A. Aquasco, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Brews CANCER Physician disease or condition resulting in death) 5 mons /Medical Examiner CANCER BREAST Sequentially list conditions, if any, leading to immediate cause. Enter Underlying. Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed and -trans resulting in death) Last Due to (or as a consequence of) burial physician sthe burial P.O. Box 68760, Physician/Medical attending p as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 menths?
1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by END STAGE RENAL DISEASE 2 No 3 ☐ Probably 4 ☐ Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes of Vital or Attending Physician: rector, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 A Residence 6 Other (Specify)
Injury at 28d. Describe how injury occurred Hospital: 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: Division 5 Pending 1 Natural 2 Accident death. investigation 1 ☐ Yes 2 ☐ No within 24 hours after deatl To the Funeral Director; completely filled in by the 6 ☐ Could not be 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Momicide To the Hospital

31. Date filed (Month, Day, Year) State Registrar

29a. Certifier

29b. Signature and title of certific

Medical

30. Name and address of person of ompleted cause of death (Item 23a) (Type, Print)

F. KRIBER, MO. 7 C POST OFFICE ROAD, WALDORF, MU 20602 32. Registrar's Signature

NUV 2 9 2004 person it sporte

DHMH 17 Rev 1/200

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D 5 0350

29d. Date signed (Month, Day, Year) Nov. 24, 2004

State of Maryland / Department of Health and Mental Hygiene [] [] [] 1 - Stete Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** NOV. 23, 2004 ISHMON EL-AMIN 8:37a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince George Hospital Cheverly Prince Geo. 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country)
OCt.30,1940 South Carolina **Funeral** 1 XM 2 F Months Days Hours Min 249-68-5050 64 Yrs. Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City. Town or Location show 10d. Inside City Limits : if Item 27 is marked other then "natural", or items 23a or 28a-f show or other traumatic event. The Madical Examinar must be notified at Maryland Prince Geo. Landover **Funeral Director** 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6504 West Forest Rd. #201 20785 or items 23a USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If Item 27 Is marked other then "natural", or Ite ☐ Yes 2 🕅 No f Yes, Give 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Food Service Jaspers Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ishmon Praileau Irine Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vinola El Amin- Wife 6504 West Forest Rd, Landover, Maryland 20785 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State eo. Wash. Cemet. 11-26-04 permit. Page Department of Important: If sny injury or once. Adelphi, Md. \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Universal II Mo 411Kennedy St, N.W., Wash, D.C. 21. Agnature of Funeral Service Licenses Mortuary C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last the attending physician and Due to (or as a coasequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐ Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has autopsy 20 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Yes 2/No Inpatient 2 ER/Outpatient 3 DOA this 27. Mapher of Feath 28a. (ate of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and agress of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

James

31. Date filed (Month, Day, Year) NOV 29

Catavenis, M.D.

32 Registrar's Signature

3001

Hospital Dr, Chevely, Md.

20785

			1 - For State	State of Mary	land / Dep		t of He	ealth an	d Mental Hy	/giene	200	,	010-
r	No. of the		Registrar  1. Decedent's Name (First, Middle, La	st)		runcate	OIL	- Laur	2. Date of D	Reg. No.	200	. 0	ne of Death
	Physic /Medi		Eugene C. Elliot	t, Sr.					November November	Day			:35 A <sup>M</sup>
	Examir		4a. Facility Name (If not institution, giv			4b. City, T	Γown, or I	Location of D			County of De		. JJ R
		4	Chester River Ho			Ches				Ke	nt		
4	Funeral Director		5. Social Security Number 6. S 218–58–0076 1	ex 7. Age (In	yrs. last birthday, 43 Yrs.	If Under 1 Months	Days	Hours N	Mrs. 8. Date of Bi (Month, D. Oct. 28	rth ay, Year) 8,196	1 9. Bi	rthplace (St. Sountry) E	ate or Foreign
	yland now		10a. State 10b. County	10	c. City, Town or L	ocation						10d. Insid	le City Limits
	r 28e-f show	ctor	MD Queen	Anne's I	Henderson	n						1 🗆	Yes 2∏ No
	or 28	Funeral Director	10e. Street and Number			10f. Zip (	Code			10g. Citiz	zen of What C	ountry?	
	s 23e	rai	3662 Goldsboro R			216				USA			
10	fter de	Fune	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 🛣 No	in U.S. 13.	Was Decede If Yes, speci	ent of His fy Cuban	panic Origin? , Mexican, Pu	(Specify Yes or No Jerto Rican, etc.)	0- 1	14. Race - Am Black, Wh		n,
036	hours after death with the Maryland tural', or items 23a or 28e-f show of Everth or must be notified at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	X No	Specify:			Specify: W	hite	
5-0	72	Completed	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual kind of work	k done du	ion iring most of	working	16b. Kir	nd of Business	s/Industry	
121	within ene. than	duic	Elementary/Secondary (0-12)	College (1-4or 5+)	Farme	DO NOT use	e retired)			Agri	cultur	•	
102	il Hygii other	a	17. Father's Name (First, Middle, Last)					18. Mother's I	Name (First, Middle				
/lar	thould be id Mental markad c matic eve	To B	Clifton A. Ellic	tt, Jr.				Virgin	ia Elliot	t Gr	een		
Maryland 21215-0036	ges 1 and 2 should be filed within to f Health and Mental Hygiene. If item 27 Is marked other then or other treumatic event, If a M.		19a. Informant's Name/Relationship (Rellie Elliott/Wi						Rural Route Numb				
e,	1 and Health em 27 ther t	15	20a. Method of Disposition		3662 Ob. Place of Dispo			Road,	Henderso				
Baltimore,	Pages 1 ar		1 ☑ Burial 2 ☐ Cremation 3 ☐  '4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemetery, crei	natory or oth	ner place)	Nov	v30,2004		eside,		9
altir	교문 환경 .	1	21. Signature of Funeral Service Licen	7			Address			_			
m —	Depa Impo eny i		Juk of H	efelio	1	JU Spe	eer .	koad,	ein & New CHesterto	wn, I	funeral D 2162	L Home 20	, P.A.
	Physician /Medical Examiner	er	23a. Part 1. Enter the disease, or companies shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	a	nsequence of):	er the mode	of dying,	such as card	diac or respiratory a	rrest,		Onset a	mate Between nd Death
58760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai Examiner	causé. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cor	nsequence of);								
.O. Box 6	that the death certificated by the attending podetached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pro 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic preg Other <i>(spe</i> d				23	3d. Date of de Month	livery Day	Year
rds, P	w requires that been signed I should be det	by	Part II. Other significant conditions co	ontributing to death but not	t resulting in the ur	nderlying cau	use given	in Part I.		_	e contribute to		
l Records,	The law re ate has bee page 2 sho	Completed									death?	utopsy findin completion o	gs available it cause of
Vital	ysician: Th	Bec	25. Was case referred to medical examiner?				2	26. Place of D	eath (Check only o		1 1 1 1 1 1 1 1	2 LI NO	
<u>o</u>	8 v =	၉	1 ☐ Yes 2 ♠No		2 ER/Outpatien		-		Home 5 ☐ Resid			cify)	
O	ing After une	tion:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yea	r) 28b. Time of Injury	M 280	Digury a Work?	t s 2 □No	28d. Describe h	now injury	occurred		
-	- i te	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp.	At home, farm, stre ecify)	eet, factory, o			28f. Location (S City or Tow	Street and vn, State)	Number or Ru	ıral Route N	umber,
	Hospit thour unare		29a. Certifier 1 Certifying Phy	rsician: To the best of my	knowledge, death	occurred at	the time,	date and pla	ce, and due to the o	cause s) a	nd manner as	stated	
	To the Hospitel of within 24 hours af To the Funaral D completely filled in	Medical	one) 29b. Signature and title of certifier	and manner stated.	and and my		License n						
1	Z 2 2 8	-	200. Organização and dita pri continer	742		29C. L	ricausa u		89	290. Date	signed (Montl	n, Day, Year	)
			30. Name and address of person who c	ompleted cause of death (	Item 23a) (Type I	Print)	) 0	X U /		111	× 1/ C	77	
			William Train	101 122 Sq	peer B.	R. O	hes	Tert	N NWO	ID	216	20	
	Star Registra		31. Date filed (Month, Day, Year)	32. Jegistrar's Si	ignature	330			,				

Herman Daniel 04-7536 AKG	Edmonds Jr Please Type or Print in Black Indelible Ink. Assure A State of Maryland / Department of Health and Certificate of Death	Mental Hygiene	201 001 -
	1. Decedent's Neme (First, Middle, Last)	Reg. No. C	3. Time of Death
Physician	Herman Daniel Edmonds, Jr.	Month Dey	Year 12.10 DM
/Medical Examiner			2004 12:19 PM
	Route 225 east of Mount Holly Lane Ripley	Char	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min	8. Dete of Birth	Birthplace (Stete or Foreign Country)
Director	215-13-0582 11X M 2 F 35 Yrs. Months Days Hours Min.	Feb. 14, 1969	Maryland
fand •	10e. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
Many a-f ah	Maryland Charles LaPlata		1 <b>X</b> □ Yes 2□ No
vith the Ma t or 28a-f a be notified	10e. Street end Number 10f. Zip Code	10g. Citizen of	What Country?
5-0020 72 hours efter death with the Maryland natural", or Nems 23a or 28a-f ahow dical Examiner must be notified at eted by Funeral Director	6875 Vernick Lane 20646	United	States
O fiter death v r tems 234 niner must Funeral	11. Meritel Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispenic Origin? (S	pecify Yes or No- 14. Ra	ce - American Indian, ick, White, etc.
020 urs efter in or h	1 Never Married 21∆ Married 1 1 Yes 2 ₺ No 1 Yes 2 ₺ No Specify:	Specifi	
Phour Phour Parkers	15. Decedent's Education 16e. Decedent's Usual Occupation		White
1 21215-0 ed within 72 ho ygiene. or than 'natura it, the Medical	(Specify only highest grede completed) (Give kind of work done during most of work life, DO NOT use retired)	rking 165. Kind of B	Business/Industry
212 d with	Elementery/Secondary (0-12) College (1-4or 5+) Electrician	Un	ion
und 2121 be filed within tal Hygiene. d other than " event, the Mo		me (First, Middle, Maiden Surnar	
aryla should it and Meni		a M. Upchurch	
Mar 12 sh hend i ia m raum	19a. Informent's Name/Relationship (Type, Print)  19b. Mailing Addrass (Street and Number or Ru		, State, Zip Code)
Baltimore, Maryland 21215-0020  permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-1 show any Injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	Darlene A. Edmonds-wife  20a. Method of Disposition  20b. Place of Disposition (Name of		
IMOR Pages ent of I nt: If ite	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, cremetory or other place)		- City or Town, State
it. P. satme ortent injury.	4 ☐ Donation 5 ☐ Other (Specify) Trinity Memorial Gardens 1  21. Signature of Funeral, Service License 22. Name and Address of Facility	1-30-04 Waldor	f, Maryland
Balt permit. Departimportumortumortumortumortumortumortumortum	21. Signature of Funeral Service License M00053  22. Name and Address of Facility Huntt Funeral Hom	ie	
	23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	dorf, MD 20604-	
Physician /Medical Examiner	Immediate Cause (Finel disease or condition  Mus Otto Ot Thousa		Approximate Interval Between Onset and Death
	resulting in deeth)  Due to (or as a consequence of):		
axecuted n and iel-transit Examiner	b.		
axecuted n and iel-transif	Sequentially list conditions, frank, leading to immediate		
	cause. Enter Underlying Cause (Disease or injury that initiated events		
Division of Vital Records, P.O. Box 6876( or Attending Physicien: The law requires that the death certificate be after death. Director: After this certificate has been signed by the ettending physicie in by the funeral director, page 2 should be detached for use es the but ettification: To Be Completed by Physician/Medical	resulting in death) Last  Due to (or as a consequence of):		
Box 68 leath certificate ettending platfor use es to describe ettending platfor use es to describe etten/Mec	d		
cords, P.O. Be wrequires that the death been signed by the ette should be detached for letted by Physicia	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use co	ntribute to the cause of death?
P.C		1 ☐ Yes 2 No	3 Probably 4 Unknown
LS, the signed be d			
al Records, The law requires the page 2 should be completed by		24a. Was an autopsy performed?	24b. Were autopsy findings aveilable prior to
Rec elaw has b ge 2 s			completion of cause of deeth?
Co		11√2Yes 2□No	1 XYes 2□ No
of Vital Records, P.O. Physician: The law requires that tha ribis certificate has been signed by the ral director, page 2 should be detached:	Hospital:	th (Check only one)	
Of Physic rithis caral direction 1: To	1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing Ho	ome 5 ☐ Residence 6XXX the 28d. Describe how injury occurr	
Division c tal or Attending P is after death. at Director: After t led in by the funare Certification:	27. Manner of Deeth  1	Deceased drivi	io, attorpted
Division of a transfer death after death Director: / d in by the ertificat	6 Could not be	28f. Location (Street and Numb City or Town, State) 624	er or Rural Route Number,
Div Is after a Dive ed in by	building, etc. (Specify)	La Plata ND	
Division of Vital R. To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate his complataly filled in by the funeral director, page  Medical Certification: To Be Com	29a. Certifier (Check only one):  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one):  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the date of examination and/or investigation.	and due to the cause(s) and ma	nnor as stated
To the H within 24 complete	ond months stated.	red at the time, date and place, a	and due to the cause(s)
To the verifier of the common N	29b. Signature end title of delifier 29c. License number		d (Month, Day, Year)
	O.C.M.E.	November	r 24, 2004
565	30. Name and address of person who completed cause of leath (Item 23e) (Type, Print)  111 Penn Street,	Baltimore. Mar	vland 21201
State Registrar	31. Dete filed (Month, Day, Yeer)  NOV 2 9 2004  32. Registrar's Signature	TALL	,
riegistrai	The state of the s		

DHMH 16 Rev 6/95

CPM 04-07562 Brenda Lynn Edwards

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year Brenda Lynn Edwards /Medical November 24, 2004 14:12 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Calvert Memorial Hospital Prince Frederick Calvert 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 11/2/195 **Funeral**  Birthplace (State or Foreign Country) 1 □ M 2 ▼ F Months 217-74-6007 47 Director D.C. Usual Residence of Decedent Maryland 10a, State iral', or Items 23s or 28s-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Calvert MD Yes 2 No Saint Leonard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 1434 Plateau Road 20685 by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. s 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other treumatic evonce. Donald Andrew Inscoe Shirley Ann Bryant 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles R. Edwards, Jr./Spouse 1434 Plateau Road, St. Leonard, MD 20685 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Cheltenham Veterans' 12/2/2004 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Immeral Service Acensee 22. Name and Address of Facility Raymond-Wood Funeral Home, P.A. 20754 PO Box 430, Dunkirk, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 0V50 Injuries disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or Injury Due to (or as a consequence of): Examine death certificate be executed anding physicien and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months? Month Year Day 4 □ Pregnant at time of death 5 Other (specify) signed by the a d be detached f 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ge 2 should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peeu 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 ☐ No has certificate al or Attending Physicien: T s after death. Il Director: After this certificat od in by the funeral director, pa 1 Xes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA 1 XYes 2 □ No 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Driverofa 281. Location (Street and Number or Rural Route Number, City or Town, State) Calvert Beach Rd 5 Pending investigation □Natural 12:19 PM involvedin a 2 Accident 24/04 1 ☐ Yes 2 ☐ Xio 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital within 24 hours at To the Funerel D ORt4 St. Leonard, M Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) anna O.C.M.E. November 25, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

P.O. Box 68760

Records,

Division of Vital

32. Registra s Signature

Blown

2004

Division of Vital Records, P.O. Box 68760

0 State Registrar

31. Date filed (Month, Day, Year) DEC 0 7 2004 2. Registrar's Signature

d cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 1tem 18 per fb 2839 1-14-05 vt. State of Maryland Abenariment of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month MARIE EUNICE FRANKLIN NOV 1:30 PM 25, 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death JOSEPH RICHEY HOSPICE Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 3-6-64 **Funeral**  Birthplace (State or Foreign Country) Days Hours Min. 1 M X F 40 Yrs. 577-82-5966 Director D.C. Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or frems 23a or 28a-1 show any injury or other traumatic avent. Its Martical Examiner must be notified at once. 10d. Inside City Limits D.C. N/A Washington Director 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4512- 3rd Street, SE #D 20032 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give A Year or Dates: Baltimore, Maryland 21215-0036 1 Yes XNo 3 Widowed 4 Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Administrative Assistant Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sur Harbison Roberta Marie Franklin Be Thomas H. Franklin ္ရ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas H. Franklin/Father 9417 Gwynndale Drive, Clinton, Md. 20735 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cem. 12/3/04 Clinton, Md. 21. Sign of Funeral Service Licenses 22. Name and Address of Facility The House of Williams Fun. Svc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** as a consequence of): /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown þ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 % known Completed Were autopsy findings available prior to completion of cause of death?
 □ Yes 2 □ No 24a. Was an has autopsy performed certificate Vital 1 Yes 2 🗓 or Attending Physician: 25. Was case referred to examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specific Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 1 🗌 Yes oť 28c. Injury at Work? 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation atural Injury 1 ☐ Yes 2 ☐ No after death I Director: / d in by the f Accident 6 Could not be determined 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar 29b. Signature and title of certifier

Registra

(Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

	Blooding		Amend Item 1&Un Amend Item 1 per 1. Decedant's Nama (First, Middla, Last)								ental Hy tas 2. Data of De Month	Reg. No.	O L <sub>4</sub>	39412 3. Tima of Death
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ē,	Heal Hem I Hem Other	Robert Fuller/husband 20639 Andrew Roa  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)									e [	20c. Location	- City or To	own, State		
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Baltimore, Maryland	permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Menlar Hygiene. Important: if them 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, if a Medical Examinat man be rollined at once.		21. Signature of Funeral Service	Licensee		22 F	Name and ellows	Address S, H	s of Facilit elfer	nbein	in & Newman Funeral Home, P.A					
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Physician NOVEMBER 5R6550 2004 JOSEPH DAVID /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HOSPITAL CENTER CHES TERTOWA RIVER HESTER 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 18 4049 83 MARCH 3. 1921 Director Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f ahow nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar admented of Health and Mantal Hygiene. Cortent: if Item 21 Is marked other than "natural", or Items 23a or 28a-1 ahow injury or other freumatic event. Ite Marked than injury or other freumatic event. Ite Marked Extending from the Internal or injury or other freumatic event. 1 Yes 2 □ No MD KENT Director HESTERTOWN 10e. Street and Number 10g. Citizen of What Country? STREET 101 Funeral 12. Was Decedent Ever in U.S. Ampd Forces? 1 MYes 2 No 179s, Give Year or Dates: 1943 - 45 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: WHITE Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Seçondary (0-12) College (1-4or 5+) 1 ECHN Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ANGELO 6 ROSSO KEGINA ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WIFE ELM STREET, 101 Date 20c. Location - City or Town, State DOROTHY 21620 GROSSO Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Department o Importent: If any injury or 104 ST. PAULS CEMETERY -AIRLES 21. Signature of Foneral Service Licensee 22. Name and Address of Facility FUNEZAL DIRECTOR MARVIN V. WILLIAMS, JR. FYNEZAL DIRECTOR 205 GREEN HERON WAY CHESTERTOWN, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) in faction pr **Physician** Myocartia /Medical Due to (or at a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or highry that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760, Certification: To Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown 9 🗆 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 - Homicide within 24 hours a To the Funeral L 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 610 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Frederick Delboy 6602 Church Hill Rd. Chestertown, MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV 1 8 2004

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					State of M	aryıar				leaith and <i>Death</i>	Mental H	, ,					
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-	/Medi Examii	cal	CATH  4e. Fecility Name (If not instit	ERIN ution, giv						4b. City, Town, o	Novem Location of Dea		2,2004 County of De		DAM		
√ _ _	Funeral Director	ier	Mariner Healt 5. Social Security Number 244-32-6018 Usual Residence of Deceder	h At 6. S	Circle Ma	anor je (In yrs.	last birthday) Yrs.			Kensingt	ON s. 8. Date of B	Mo irth Dey, Year)	ntgome		e or Foreign ina		
	and ww		Usual Residence of Deceder 10a. State 10b. Co			10c. Cit	ty, Town or Lo	cation	<u> </u>	<u> </u>				10d. Inside	City Limits		
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	th with the 23a or 28a	Funeral Director	10e. Street and Number 10231 Carroll	P1a	ce				p Code 2089.	5		_	zen of Whet (	Country?			
020	be filed within 72 hours efter death with the Maryland that Hygiene. od other than "natural", or items 23a or 23a-f show event, the Medical Examiner must be notified at	by Fune	11. Marital Status 1 □ Never Married 2 □ 3 ∰ Widowed 4 □ Divo		12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐ If If Yes, Give X Year or Dates:			Vas Dece Yes, spe		lispanic Origin? ( an, Mexican, Pue Specify:	Specify Yes or N rto Rican, etc.)		14. Race - An Black, Wh Specify: B1				
2-0	72 hou	sted	15. Dece (Specify only hi	dent's Ed	lucation		16e. Deced	ent's Usu	el Occup	petion during most of we d)							
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and	0 - 0 >	Be	Pierce Williams  19a. Informant's Name/Relationship (Type, Print)  Grover McDonald/Son  Katie N  19b. Mailing Address (Street and Number or 4256 Benning Road, NE									me (First, Middle, Maiden Surname)					
aryl	should nd Me mark meric	ပ										cDonald					
ž	end 2 saith a 127 is er trat																
Baltimore, Maryland 21215-0020	permit. Pages 1 and 2 should b Department of Health and Mente Important: If item 27 is marked any injury or other traumatic a once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremat 4 ☐ Donation 5 ☐ Other	on 3 □ r <i>(Specif</i> )	Removal from State		Place of Dispo- cemetery, cren ar Hill				Date 11/26/04		cation - City o	r Town, State			
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Ċ			23a. Part1. Enter the disease shock, or heart failure.	, or comp List only	olications thet caused one ceuse on each li	the deat ne.	h. Do not ente	or the mod	de of dyir	ng, such es cardia	ac or respiratory	arrest,		Approxim Intervel B Onset an	ate etween d Death		
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	Sta Registr		31. Date filed Month, Day, Y	<sup>2</sup> 2004	. Registra	ar's Signa	ture	19,									

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			1 - For Stata Registrar	State of Marylan	-					39417
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			HOWARD COUNTY  5. Social Security Number 6. Sex			Ab. City, Town, or Location of Death   Ac. County of Death   Ac.				
ŀ	Funeral Director		-	M 2CSF 92				(Month, Day, Oct. 19	,1912 N	laryland
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ore,	of Health of Health fitem 27		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Re		Place of Dispo	sition (Name of matory or other plac	се)	Date 2	0c. Location - City or	Town, State
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u	To the within To the comp		29b. Signature and title of certifier			29c. Licens	e number	290	d. Date signed (Mont	th, Day, Year)
	.1		MINS, MD	FCCP		236	845	1	NOV. 23	2004
	,		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type,	Print) MAI	-CH1	NGUYER	1, MD, F	-ccp
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	Registr	rar	NOV 2 9 2004	Sheva	B	sports	1			

			For Stata Registrar	State of M	larylan		artment of F		nd Mental H	ygiene Rag. N	C U U U U	39418
	Dhuaiai		1. Decedent's Name (First, Middle	, Last)		-			2. Date of Month	Death Da	y Year	3. Time of Death
	Physici /Medic		SANG KON KIN						Novem	ber :	25 2004	
	Examin	ner	4a. Facility Name (If not institution		-)		4b. City, Town, or			40	. County of Dea	
			Holy Cross Hos  5. Social Security Number		ae (In vrs.	last birthday)	Silver If Under 1 Year	Sprin		Birth	Montgom	
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	shov	5	10a. State 10b. County			y,TownorLo lver S						10d. Inside City Limits 11 Yes 2 □ No
	28a-f	Director	Maryland Montg	Smery	31	TAGE 2	10f. Zip Code			10g Ci	itizen of What Co	
	3a or	Ö	703 Brandon Gre	en Drive			20904				.S.A.	Surray .
	death	Funeral	11. Marital Status	12. Was Deceden Armed Forces			Was Decedent of H	ispanic Origin	in? (Specify Yes or Puerto Rican, etc.)		14. Race - Ame	
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Maryland 21215-0036	d 2 sh th and 7 Is m traum		19a. Informant's Name/Relationsh John N. Kim/So						or Rural Route Num			
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Baltimore,	permit. Pages 1 Department of H Importent: If ite any injury or ot once.		21. Signature of Funeral Service		[e.	22	Name and Address	se of Equiliby	NERAL HOM			naryrana
<u> </u>	89 = 29		Nancy A	. Vercon	Tre	11	800 New I	Hampsh	ire Ave.	Silve	NC. er Sprin	ng, MD 20904
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	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. License	e number			te signed (Monti	
	3		) (m	luo			D-32	247		No	vember 2	26, 2004
			30. Name and address of person Nuushin Farr, I	4.D., 1500				lver S	Spring, Ma	aryla	nd 2091(	)
:-	Sta Registr		31. Date filed (Month, Day, Year) NOV 29	2004 32. Regis	trar's Signa	- A	pork	201				

	ian	1. Decedent's Name <i>(First, Middl</i> e, Norman Albert L	,						2. Date of De Month Novemb	Day	Year	3. Time of D
/Medi Examir		4a. Facility Name (If not institution,			4b. City.	. Town. or	Location o	of Death	Novemb		nty of Death	
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uneral irector		5. Social Security Number 6 219-30-5029	.Sex 7.Age	(In yrs. last birthda 70 Yrs.	y) If Under Months		If Under 2 Hours	Min	8. Date of Bin (Month, Da Oct. 13	th Year) 1934	9. Birth	nplace (State or a
*		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location							10d. Inside City
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or Itams	by Funeral	11. Marital Status  1 □ Never Married 2 【 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces?  1 □XYes 2□N If Yes, Give Year or Dates:		B. Was Deced If Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)		lace - Amer lack, White city: Whi	, etc.
	eted	15. Decedent's (Specify only highest of	Education	16a. Dec	edent's Usua ve kind of wo	al Occupa	tion	of worki	na	16b. Kind of	Business/li	ndustry
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d other than "natu avent, I'm Medical		17. Father's Name (First, Middle, La	St)	AILI	line P		19 Mothor	r's Nome	(First, Middle,	Airli		
and Mental Hygiene. is marked other than aumatic avent, the Ms	) Be	Frank Little	31)						Bradbur		ame)	
	L C	19a. Informant's Name/Relationship	(Type, Print)	19b. Mai	ing Address (Street and Number or Rural Route Number						m State Zi	'n Code)
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nt: If itam 27 is marke ry or other traumatic	5.779	20a. Method of Disposition  1 XBurial 2 Cremation 3  4 Donation 5 Other (Special Control of Control		20b. Place of Disp cemetery, cri Galena	ematory or o	other place			27,2004	20c. Location	•	own, State
Important: If ita any injury or ot once.		21. Signature of Funeral Service Lic		2 5 1	22. Name an Fellows	nd Address	s of Facility	, bein		am Fun	eral	Home, P
edical			Due to (or as a			KP 1		, –				1 1
miner paragraph and parial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause first and advanged Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a	consequence of):  consequence of):								
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State of Maryland / Department of Health and Mental Hygiene 00 is 39420 1 - For State Registrar Certificate of Death Rag. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** November 27, 2004 Edith Lydia Landsburg 12:10PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Casey House Rockville If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Yrs Director 95 Michigan 379-52-9893 Jan. 18, 1909 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits r then "naturel", or Itams 23a or 28e-f show The Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Montgomery <u>Silver</u> Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 410 Torrington Place 20904 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If tiem 27 is marked other then "naturel", or than any injury or other traumatic avent, the Medical Examinations. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify. þ 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Home Economics Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Charles F. Whipple Anna B. Lentz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alexander C. Landsburg/son 307 Williamsburg Drive Silver Spring, MD 20901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State November 29. 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arundel Crematory 2004 Odenton, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician a. Advanced Alzheimer's Dementia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Under, in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of) Box 68760. physician Physician/Medical 98 IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Day Month Year 4□Pregnant at time of death 5 Other (specify) Records, P.O. the detached 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Recurrent Pneumonia, Atrial Fibrillation 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has 1 ☐ Yes 2X No Division of Vital Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Dthen:  $_{4}$  Nursing Home  $_{5}$  Residence  $_{6}$  X ther (Specify)  $_{hos}$  ice Hospital: 1 ☐ Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient P 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: To the Hospital or Attending 1 XXIatural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death the 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funerel C

completely filled i 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature and title of co 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Harrison M.D. 6001 Muncaster Mill Road Rockville, Maryland 20852 gistrar's Signature 31. Date filed (Month Day, State 3 0 2004 Registrar

		•	1 - For State Registrar	State of Ma	aryland /	Departme Certifica				giene Reg. No. 20	04 3942
	Physici /Medic	al	Decedent's Name (First, Middle, Last     MICHAEI	. R. M	IATHIS				2. Date of Dea Month	Bay 20	04 12:13 PM
	Examin	er	4a. Facility Name (If not institution, give	street and number)	tal	4b. City	Town, or	Location of Death		4c. County of C	GOMMY
	Funeral Director		5. Social Security Number 6. Se  NONE	7. Ago Mg M 2□F	e (In yrs. last	Yrs. If Undo	Days	Hours Min.	8. Date of Birt (Month, Day DEC. 6		Birthplace (State or Foreign Country) MARYLAND
	land bw		Usual Residence of Decedent  10a. State 10b. County	-	10c. City, To	own or Location					10d. Inside City Limits
	e Mary	Director	MD. MONTGOMI	ERY		GE	RMANT	OWN			1 Yes 2 □ No
	with th		10e. Street and Number  17814 FAIRLADS	, mv		10f. Z	ip Code 20	874		10g. Citizen of Wha	•
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene Important: if Item 27 is marked other than "naturel", or Items 23a or 28a-f show empty injury or other traumatic event, the Modified Extrinute from the Incillis of an Once.	Completed by Funeral	11. Marital Status  1  Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		13. Was Dec If Yes, sp	edent of His ecify Cubar		pecify Yes or No- to Rican, etc.)		American Indian, White, etc.
21215-0036	"natur	leted	15. Decedent's Ed (Specify only highest grad		16	6a. Decedent's Us (Give kind of w life. DO NOT	ork done d	urina most of wor	rking	16b. Kind of Busin	
212	giene. er than	Somp	Elementary/Secondary (0-12)	College (1-4or 5	5+)		NE			N	ONE
	d be file intal Hy ed oth	Be	17. Father's Name (First, Middle, Last)  BURMAN	MATHIS					ne (First, Middle, DIANE	WOLFE	
Maryland	2 should and Men le marke surmatic	J.	19a. Informant's Name/Relationship (7		1	9b. Mailing Addres	ss (Street a			er, City or Town, Sta	te, Zip Code)
	1 and 1 Health em 27		BURMAN MATHIS 20a. Method of Disposition	/FATHER	20b. Place	of Disposition (N	ame of		Date Date	N, MD. 20 20c. Location - City	
Baltimore,	Pages nent of I ant: If Its ury or o		1 ☐ Burial 2 【Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State		atery, crematory or <b>IBERS CRE</b>		- 1	8-2004	RIVERDA	
Balti	permit. Departn Imports eny inji		21. Signature of Funeral Service Licent	mbersa	2 <sub>M0009</sub>	CHAME	ERS F	s ot Facility UNERAL 1 LAND AV	HOME & C	REMATORIU RDALE, MD	M,P.A. 20737
	Dhusisian		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	lications that caused one cause on each lin	ne.				c or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as	a consequen	oremat	UI II	7			
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequenc	ce ot):					
,092	ate be executed hysicien and he burial-transit	cal Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a consequent	ce of):					
89	rtificate ng phys as the		IF FEMALE:	d							
.O. Box	res that the death certifica igned by the attending ph be detached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal dea	ath 3 ☐ Ectopic				23d. Date of Month	delivery Day Year 6 2004
Δ.	uires that n signed b	þ	Part II. Other significant conditions co	ontributing to death b	out not resultin	g in the underlying	cause give	in in Part I.	23e. Did to	/	te to the cause of death?  Probably 4 Unknown
Vital Records,	The law requires that the rate has been signed by the page 2 should be detache	Completed								rmed? prior deal	e autopsy findings available to completion of cause of h? Yes 2□ No
/ital	10	Be	25. Was case reterred to medical examiner?	Hospital:			Othe		ath (Check only o	one)	
of	sing Physian.	lon: To	27. Manner of Death  1 Natural 5 Pending	28a. Date of Inju	iry 28	Outpatient 3 [ b. Time of Injury  M	28c. Injury Work	at at		dence 6 Other (	Specify)
Division	death death ctor: y the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj	jury - At home ic. (Specify)	, tarm, street, tacto			28f. Location (S City or Tox		or Rural Route Number,
	To the Hospitel or within 24 hours after To the Funeral Director completely filled in b	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best niner: On the basis o and manner st	t examination	dge, death occurre and/or investigation	d at the tim on, in my op	e, date and place pinion, death occu	e, and due to the turred at the time,	cause(s) and manne date and place, and	or as stated. due to the cause(s)
	To the within To the	Me	29b. Signature and title of certifier	1110		2	9c. License		. 4	29d. Date signed (A	fonth, Day, Year)
)			20 Name and address of access	Ompleted to the state of the st	leath /ltc= CC	la) (Tuna Brist)		55448		12/6	104
_			Avarey Scides,	MD cause of	22201	Plum (	Srche	and the	ive, Sil	ver Spri	9, MD
100	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registr	rar's Signature	4	doar	6			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

				1 - For State Registrer	State of M	-	epartment of Certificate of		vientai Hy	/giene Reg.N€) ∩	0.1	00100
		Physici	20	1. Decedent's Name (First, Mid	dle, Last)		7		2. Date of D		Year /	3t Time of Death
		/Media	cal	GERARD E.	MAYER				1	19	04	1945 PM
	4	Examir	ner	4a. Facility Name (If not institution PENINSULA REG		CENTED		or Location of Death	ו	4c. County	MICO	
		Funeral		5. Social Security Number		e (In yrs. last birti	hday) If Under 1 Year	If Under 24 Hrs.	8. Date of Bi			place (State or Foreign
	ш	Director		102-28-5522	1 <b>&amp;</b> M 2□ F	71	rs. Months Days	Hours Min.	8. Date of Bi (Month, D <b>JAN - 14</b>	,1933	NEW	YORK
		and w		Usual Residence of Decedent  10a. State 10b. Coun	ty	10c. City, Town	or Location				1	0d. Inside City Limits
		Maryl -f sho	tor	DELAWARE SU	SSEX	LEWE	ts.					1 ☐ Yes 2 No
		with the Maryland to or 28a-f show	Director	10e. Street and Number	JULIE		10f. Zip Code			10g. Citizen of	What Coun	itry?
		23e c	ralD	23584 HOLLY	CIRCLE, WDS.O	N HERRIN		958		USA		
		er death Items 23	Funeral	11. Marital Status	12. Was Decedent Amed Forces?		13. Was Decedent of If Yes, specify Cul	Hispanic Origin? (Sp ban, Mexican, Puert	pecify Yes or N o Rican, etc.)	o- 14. Rad Bla	ce - Americ ck, White,	
	36	72 hours after neture!; or Ite dical Exertine	by F	1 ☐ Never Married 2 🛣 Ma 3 ☐ Widowed 4 ☐ Divorce	If Yes, Give	<b>NO</b>	1 ☐ Yes 2X No	Specify:		Specif	y: W	HITE
	Maryland 21215-0036	72 hou	ted	15. Decede	ent's Education lest grade completed)	16a.	Decedent's Usual Occu	pation	king	16b. Kind of B	usiness/Inc	dustry
	21	within ene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)	(Give kind of work done life. DO NOT use retire		Kirig	CT ACCT	JADE 1	ANUFACTURI)
	2	filed w Hygien other ti		17. Father's Name (First, Middle	4 (ast)		SALES MANA	GER 18. Mother's Nam	ne (First Middle			IANUFACIUKI
	au	d be i	To Be	GERARD G.	MAYER			MILDRED			10)	
	ary	2 should be filed within n and Mental Hygiene. is marked other then reumetic event, the M	-	19a. Informant's Name/Relation		196.	Mailing Address (Stree			<del></del>	State, Zip	Code 19958
		ss 1 and 2 of Health a item 27 is		VIRGINIA M. 1	AYER/WIFE	23	584 HOLLY					
133	Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "neturel", or Items 23e or 28e-f show eny injury or other treumetic event, the Madical Examinar must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 4 ☐ Donation 5 ☐ Other	n 3 □Removal from State (Specify)	EASTER	Disposition (Name of SHORE)  Note the plant of the plant	11/:	Date 22/04	LEWES,	-	
1/14/3	Balti	permit. Pages Department of I Importent: If ite eny injury or of		21. Signature of Funeral Service	MOO866	OICLE	PARSELL AT	ONERAL'Y HOL	MES & C	REMATORI	UM	
				23a. Part1. Enter the disease,	or complications that caused st only one cause on each line	the death. Do n					9958	Approximate
		Physician		Immediate Cause (Final disease or condition	st only one cause on each	(1.1/e	Myocom	lial To	fort	2000		Interval Between Onset and Death
		/Medical		resulting in death)	Due to (or as	a consequence o	of):	1017 321		_		
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4	ó	ificate be executed g physician and as the burial-transit	Еха	resulting in death) Last	c. Due to (or as	a consequence o	f):					
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161/	0	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death	5 Other (specify)					
7	s, P	requires that the een signed by th nould be detache	by Pr	Part II. Other significant condi	tions contributing to death b	ut not resulting in	the underlying cause gr	ven in Part I.	23e. Did	tobacco use cont	ribute to th	e cause of death?
	rds	w requires that been signed should be de							1 🗆	Yes 2□No	3 🗆 Proba	ably 4 Unknown
W.	ecord	₹ 0 0	Completed						24a. Was		Were autor	osy findings available inpletion of cause of
3	$\alpha$	The cate he page	Соп						perfe 1 ☐ Yes	ormed?	death? 1 🗌 Yes	
S)	Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medic examiner?	Henritals /		Ct	26. Place of Dea				
	ō	Phys rthis raldii	To :	1 ☐ Yes 20€ No 27. Manner of Death	1 Inpatie		patient 3 DOA	4 🗌 Nursing H		idence 6 Oth how injury occurs		)
3	on	Attending F r death. ector: After by the funer	atlor	1 Natural 5 Pend 2 Accident inves	ing (Month, Da tigation	y <i>Year)</i> In	jury Wo	ork? ]Yes 2∐No		,,		
3	Divisi	r Attendi er death. rector: A by the fu	Certification:	3 ☐ Suicide 6 ☐ Coul	d not be mined 28e. Place of Inj. building, et	ury - At home, far	m, street, factory, office		28f. Location (	Street and Numb wn, State)	er or Rural	Route Number,
2	Ö	itel or irs aft rel Di led in	Cer									
		To the Hospitel or Attending Physicien: The lawithin 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier 12 Certify (Check only one) Medica	ing Physician: To the best il Examiner: On the basis of and manner sta	examination and	death occurred at the t Vor investigation, in my	ime, date and place, opinion, death occur	and due to the rred at the time,	cause(s) and ma date and place,	inner as sta and due to	ited. the cause(s)
		To the To the Comp	Σ	29b. Signature and title Certif	4 )/		29c. Licen	se number		29d. Date signed	1 (Month, E	lay, Year)
							1 1 2 3	2212		11/19/	64	
				30. Name address person		eath (Item 23a) (T	Type, Print)	lisbury,	m /	21801		
		Sta	ite	31. Date filed (Month, Day, Yea	7,1	ar's Signature	AV. EU	usbury,	10101.	×1801		
		Registr		NOV 24	2004 Shar	מן היי	Sporta	1				

		•	1 - For Stata Ragistrar	State of Ma	aryland / Depa <i>Ce</i>	artment of H		nd Mental H	lygiene	nnı.	20122
	Physici		1. Decedent's Name (First, Middle, Last	,	. Marshall			2. Date of Month	- 1	2004	3. Time of Death 9:40 P. M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of			ounty of Death	7.40 1.
	LAGITIT	Ü.	Crofton Nursing	Center		Crofton	n		Ann	e Arund	le1
	Funeral		5. Social Security Number 6. Se	x 7. Age	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hours	Min. (Month,	Day, Year)	9. Birtho	place (State or Foreign
	Director		226-18-1960 1L Usual Residence of Decedent		98 Yrs.			Feb.	22,1906	Virg	
	land land		10a. State 10b. County		10c. City, Town or Lo	ocation				1	10d. Inside City Limits
	Mary I sh	ţō	Maryland Prince Go	eorge's	Forestvi	11e					1 ☐ Yes 2 No
	or 288	Director	10e. Street and Number			10f. Zip Code			10g. Citizer	n of What Cour	ntry?
	23a c		8212 Richville Dr:	ive		20747	7		USA		
	r dea	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origir In, Mexican, I	n? (Specify Yes or Puerto Rican, etc.)	No- 14.	Race - Americ Black, White,	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I'm Madical Examination and Le indiffical at ODGE.	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ⊟Yes 2 🐧 N If Yes, Give Year or Dates:	NO .		Specify:			рөcify:Wh <b>i</b> t	
9	tural	edt	15. Decedent's Edu		16a. Dece	dent's Usual Occupa	ation		16b. Kind	of Business/Inc	dustry
215	nin 72	Completed	(Specify only highest grad Elementary/Secondary (0-12)	de completed)  College (1-4or 5	(Give	kind of work done of DO NOT use retired	durina most o	of working			
21	ad with	Com	7	0011090 (1 101 0		ntress				thing	
Maryland 21215-0036	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)					s Name (First, Mid	dle, Maiden Su	mame)	
yla	Man Marka Marka Marka	ို	John C. Montgomer		122	(2)		ie Niten			
Mai	d 2 sh th and 7 Is n traun	11	19a. Informant's Name/Relationship (T)		1	ng Address <i>(Street a</i> Richville					
	Heal Heal tem 2		Mary F. Killerland 20a. Method of Disposition	e (daugnte	20b. Place of Dispo	sition (Name of		Date		MD 207 tion - City or To	
Baltimore,	ages ent of nt: If I		1 M Burial 2 ☐ Cremation 3 ☐ F 1 4 ☐ Donation 5 ☐ Other (Specify)			matory or other place n Nat. Cer	· 1	12/10/20	04 Ar1	ington.	VA
altir	nit. F partme cortan injur	- 1	21. Signature of Funeral Service Licens			2. Name and Addres			-		111
ñ	Depar Impo		Benerly	Cm. B		512 N.W. (				20715	
			23a. Part1. Enter the disease, or composhock, or heart failure. List only of	lications that caused ne cause on each lig	the death. Do not ent	er the mode of dying	g, such as ca	ardiac or respirator	y arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. /	) omen	. tià					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):	1					2
ı	EAGIIIII07	J.	Sequentially list conditions,	b. Due to for as:	J y S	phagio	r			-	5-34
	nsit	Examine	n any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or us	a consequence						
Ć,	execu n and ial-tra	Exal	that initiated events resulting in death) Last	C. Due to (or as	a consequence of):					- 1	
8760,	the death certificate be executed y the attending physician and tched for use as the burial-transit	dicai		d							
9	rtifica ng ph a as th	Med	IF FEMALE:								
Вох	eath certific attending p I for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy			23d	Date of delive     Month	ery Day Year
o.	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death 5	Other (specify)			-		
Δ.	that ed b deta		Part II. Other significant conditions co	ntributing to death be	ut not resulting in the u	nderlying cause give	en in Part I.	23e. D	d tobacco use	contribute to th	ne cause of death?
ecords,	es De	d by						11	JYes 2□N	lo 3 ☐ Prob	pably 4 Junknown
00	> 11 ()	olete						24a. W	as an 2	4b. Were auto	psy findings available
α,	0 - 0	Completed						— au pe 1 ☐ Ye	topsy rformed?	prior to cor death? 1 \(\sum \) Yes	mpletion of cause of
Vital	ician: Th certificate ector, pag	0	25. Was case reterred to medical				26. Place of	f Death (Check on		1 1 1 63	20 110
	y S	To B	examiner? 1 Yes 2 No	Hospital: 1 🗆 Inpatie		nt 3 DOA Othe	er: 4. ⊡ Hours	ing Home 5□ R	esidence 6	Other (Specify	1)
n o	ing P	on:	27. Manner of Death 1 → Hatural 5 → Pending	28a. Date of Injus (Month, Day	y Year) 28b. Time o Injury	Work			e how injury o	ccurred	
isio	Attanding r death. actor: After	icati	2 Accident investigation 3 Suicide 6 Could not be	20a Blace of Init	A hama farm at		Yes 2 □ No		(Chant and h	tumber of Burn	1 David March 2
Division of	if or Attand after death Diractor: /	Certification:	4 Homicide determined	building, etc	ury - At home, farm, str c. (Specify)	eet, factory, office		City or	Town, State)	umper or Hura.	l Route Number,
	Hospital 14 hours a Funeral C		29a. Certifier 1 Cartifying Phy	sician: To the best of	of my knowledge, deat	h occurred at the tim	ne, date and	place, and due to t	ne cause(s) and	d manner as st	ated.
	To the Hospital or Atlanding Ph within 24 hours after death. To the Funeral Diractor: After th completely filled in by the funeral	edical	(Check only 2 Madical Exami	inar: On the basis of and manner sta	examination and/or in	vestigation, in my op	oinion, death	occurred at the tim	e, date and pla	ice, and due to	the cause(s)
	To the vithing to the comp	Ä	29b. Signature and title of certifier	- 1		29c. License		- 44	29d. Date s	igned (Month, I	Day, Year)
_	2		Hony 14	eg_	m	1)	358	48	. 11/	2610	7
R	19		30. Name and address of person who can Howard K. Schult				e. 201	l, Gambri	11s, Ma	1. 2105	4
	Sta Registr		31. Date filed (Month, Day, Year) <b>NOV 2 9 2004</b>		ar's Signature	E)					

	-27-12		1 - For State Registrar	State of Maryland / De	partment of Health and Nertificate of Death	Mental Hygie	
	Physic	ian	Decedent's Name (First, Middle, Las	,		2. Date of Death Month	Day Year 3. Time of Death
1	/Medi		WALTER AARON	MODANCE		November	27 2004 7:00 A <sup>M</sup>
	Exami	ner	4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death		4c. County of Death
*		- 4	Suburban Hospita		Bethesda		Montgomery
	Funeral Director		5. Social Security Number 6. Se 117-03-6026	MM 2DF	Months Days Hours Min	8. Date of Birth (Month, Day, Ye	
	道 do Ac		Usual Residence of Decedent	85 Yrs.		April 28	,1919 Bronx, N.Y.
	yland now		10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Limits
	Mar Mar	to	Maryland Montgome	ry Betheso	da		11∑ Yes 2 □ No
	th the	lrec	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?
	72 hours after death with the Maryland natural', or Items 23a or 28a-f show dual Examiner must be notilled at	Funeral Director	5450 Whitley Park	Terrace	20814		U.S.A.
	s dea	Iner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? 107.7	3. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,
98	or it	Y.	1 ☐ Never Married 2X Married	Armed Forces? 1 図Yes 2 □ No 1944 If Yes, Give	1 ☐ Yes 2 ☒ No Specify:	rticari, etc.)	Black, White, etc.
21215-0036	ural.	d by	3 Widowed 4 Divorced	Year or Dates: 1946			Specify: White
5	within 72 ho iene. r than "natu	Completed	15. Decedent's Ed (Specify only highest grad	de completed) 16a. De (Gi	cedent's Usual Occupation ive kind of work done during most of work o. DO NOT use retired)	ing 16b	. Kind of Business/Industry
72	within ene. than	ш	Elementary/Secondary (0-12)	College (1-40r5+)			Lega1
d 2	be filed tal Hygi d other		17. Father's Name (First, Middle, Last)	Ji Pa	atent Attorney	e (First, Middle, Maid	
an	D la la	To Be	Harry Modance				on Sunamo,
Maryland	2 should and Men Is marke sumatic	F	19a. Informant's Name/Relationship (T	ype, Print) 19b, Ma	illing Address (Street and Number or Rur	Modance	ty or Town State Zin Code)
Ma		1	Marilyn A. Bagel		7 Rockhurst Road, E		
ē,	itam 27 I	- 6	20a. Method of Disposition	20b. Place of Dis			. Location - City or Town, State
E O	age 11. 20		1 ☑ Burial 2 ☐ Cremation 3 ☐ I  3 ☐ Other (Specify)	181110Val II OIII State	Memorial Gardens		ney, Maryland
Baltimore,	permit. Pages 1 Department of H Important: If its any injury or oth		21. Signature of Funeral Service Licens	000	22 Name and Address of Equility		
ä	Deg Park		Nancy A.	Percentio	HINES-RINALDT FUNET	RAL HOME.	INC. er Spring, MD 20904
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	ications that caused the death. Do not ene cause on each line.  a. Metastatic Colon  Due to (or as a consequence of):	enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death 1 Year
68760,	ficate be executed physician and sthe burial-transit	edical Examiner	Sequentially list conditions, a.y. leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):  d.			
.O. Box	that the death certifica ed by the attending ph detached for use as tt	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		B ⊟Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
ords, P	The law requires that the tee bas been signed by the bage 2 should be detache	þ	Part II. Other significant conditions co	ntributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?  2 🖾 No 3 🗆 Probably 4 🗀 Unknown
al Record	id cr	Completed	25. Was case referred to medical			24a. Was an autopsy performed:	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
Vital	Physician: this certific ral director,	o Be	examiner?	Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpati	O4h +	(Check only one)	
ion of	ding After fune	$\vdash$	27. Manner of Death  1 XNatural 5 Pending 2 Accident investigation	1 ☑ Inpatient 2 ☐ ER/Outpatient 2Ba. Date of Injury (Month, Day Year) Injury	of 28c. Injury at	me 5 ∐ Residence 28d. Describe how in	6 ☐Other (Specify) njury occurred
Division	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)		City or Town, Sta	
	To the Hosp within 24 hor To the Fune completely fi	Medical	one)	sician: To the best of my knowledge, dea ner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurr	ed at the time, date a	and place, and due to the cause(s)
1	To Too		29b. Signature and title of certifier	/ //	29c. License number	29d. [	Date signed (Month, Day, Year)
7	72		X	MO	D0033293	No	ovember 27, 2004
	V			impleted cause of death (Item 23a) (Type			
E.			Frederick P. Smit 31. Date filed (Month, Day, Year)	th, M.D., 5455 Wisc	consin Avenue, Chev	y Chase, N	Maryland 20815
*	Sta Registr		NOV 2 9 200	32. Registrar's Signature	Sparks		

			For 1 == State Registrar	State	of Marylan	-	artment of F		Mental H	Hygier Reg. N	/ 11	04	39425
1			Decedent's Name (First, Middle	e, Last)	- · · · ·				2. Date of Month	Death	Day	Yeer	3. Time of Death
	Physicia /Medic		Lillya:	1	He1en		Maisti		Novem	ber 2	21, 2	004	7:05p <sup>M</sup>
	Examin	-	4a. Facility Name (If not institution Hillhaven Nurs	_				r Location of Dea	ith		4c. County		
			5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	Ade1ph If Under 1 Year		s. 8. Date of		Princ		olace (State or Foreign
	Funeral Director		579 03 6740	1 ☐ M 2 🛣 F	92	Yrs.	Months Days	Hours Min	July	, Day, Yea	1912	Cour	nington,D.C.
	pu 🖈		Usual Residence of Decedent  10a. State 10b. County		10c Cit	ty, Town or Lo	cation						0d. Inside City Limits
	Maryla f shor	ō		e George		llege I							1 ☐ Yes ZONo
	r 28e-	Director	10e. Street and Number	e debige	.5 00.	riege i	10f. Zip Code		<u></u>	10g. (	Citizen of V	What Cour	ntry?
	within 72 hours after death with the Maryland ene. than "neturel", or Items 23e or 28e-f show the Madical Excirction in the motified at		9241 Limestone I	Place			2	0740			US	A	
	tems	Funeral	11. Marital Status	Armed		.S. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Origin? ( an, Mexican, Pue	Specify Yes or rto Rican, etc.	r No- )		e - Americ ck, White,	ean Indian, etc.
2	rs afte	by Fi	1 ☐ Never Married 2 ☐ Marr 3 🛣 Widowed 4 ☐ Divorced	ied 1 Tes If Yes, 0 Year or	; 2. 2 ⊠No Bive Dates:		1 ☐ Yes 2 🕱 No	Specify:			Specify	/: Whi	ite
3	2 hou eture	ted	15. Deceden	t's Education		16a. Dece	dent's Usual Occup	ation	a deia a	16b.	Kind of B	usiness/In	dustry
7 13	thin 7.	Completed	(Specify only higher Elementary/Secondary (0-12)	T	(1-4or 5+)	life.	kind of work done DO NOT use retired	d)	*				
7	ygien ygien her th		12	1 1		Pers	sonnel Re	presenta 18. Mother's Na		dalla Adaid		UD_	
	ntal Hedol	Be	17. Father's Name (First, Middle, John E. Brennan	Last)				Lillie	мае ( <i>First, міс</i>		aley	18)	
Ž	should nd Me mark matic	٦	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address (Street					State, Zip	Code)
N N	alth ar 27 le 27 le		Rose M. Palmer	/ Daught	er	HC83	Box38B	Augusta.	West	Virgi	inia	267	704
e,	of Head		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name of matory or other place		Date		Location -		
Ĕ	Page ment ent: It		12 de la company de la compan		Gat								ing,Marylan
Daltimor	permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Deparmit of Health and Mental Hygiene. Important: If item 27 le marked other than "neturel, or Items 23e or 28e-f show eny Injury or other treumatic event. Ite Marylan Exciminational to mailined at once.		21. Signature of Funeral Stryice	Licensee Cu	du -		2. Name and Addre						Home MD 20904
Ž,			23a. Part1. Enter the disease, or shock, or hear failure. List	complications that	t caused the deat	th. Do not ent	er the mode of dyir	ng, such as cardia	ac or respirator	ry arrest,			Approximate Interval Between
	Physician		Imm diate Cause (Final disea	-a Ac	JE I	24064	ELIAL I	NEARLY	LOI				Onset and Death
	/Medical Examiner		resulting in death)	Due t	o (or as a consec								
		P.	Sequentially list conditions, if any, leading to immediate		o (or a a consec		HEARI	FAIL	ングミ			-	-
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate many. Enter Inderlying Cause (Disease or injury that initiated events										
Ď,	e exectian an	Exa	resulting in death) Last	Due t	o (or as a consec	quence of):							
0/9	ate be hysici the bu	dlcal		d									
ο Ο Ο	the death certificate be executed y the attending physician and tched for use as the buriat-transit	0	IF FEMALE:	23c If yes	outcome of pregna	ancv					22d Da	to of doline	201
0	atten	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Feta	al death 3	Ectopic pregnancy Other (specify)	/				te of delive inth	Day Year
j.	n requires that the de been signed by the should be detached	hysi	1 Yes 2 No 9 Unknown	9ŪUnl									
r,	requires that een signed b nould be deta	by P	Part II. Other significant condition	ons contributing to	death but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. D			ribute to th	ne cause of death?
cords	equire en siç ould b		CONDROCATE	21204					1	Yes	2 No	3 Prob	pably 4 Unknown
ecc	2 is a	Completed	HYPOTHY ROID	1507					a	Vas an utopsy		prior to co	psy findings available mpletion of cause of
	Th pag		CSTEDPOROS						1 □ Ye		No	death? 1 🗌 Yes	2 🗆 No
VItal	iding Physiclen: th. : After this certifica ; tuneral director, p	o Be	25. Was case referred to medica examiner?	Hospital:	☐Inpatient 2☐	] ER/Outpatier	nt 3□ DOA Oth	26. Place of De	eath <i>(Check or</i> Home 5 🗆 F		c No.	1-215	reb LIVING
0	Physer this eral di	-	1 ☐ Yes 2 No 27. Manner of Death	28a. Da	te of Injury	28b. Time o	f 28c. Injur	y at	28d. Descri				y)
0	Attending r death. ector: After you the fune	atloi	1 Natural 5 Pendir 2 Accident investi	ig i	onth, Day Year)	Injury	M 1 🗆	Yes 2 □ No	1				
DIVISION	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	inod   286. Pla	ce of Injury - At h Iding, etc. (Speci	ome, farm, str	eet, factory, office			on (Street Town, Sta		er or Rura	l Route Number,
2	iltel o irs aft rel Di												
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Afte completely filled in by the fun	Medical	29a. Certifier 1 Certifyir (Check only 2 Medical	Examiner: On the	he best of my kno basis of examina anner stated.	owledge, deat ation and/or in	h occurred at the tir vestigation, in my o	me, date and place pinion, death occ	ce, and due to curred at the tir	the cause me, date a	(s) and ma and place,	anner as si and due to	tated. o the cause(s)
	ro the vithin or the comple	Me	29b. Signature and title of gentile		5101041		29c. Licens	e number		29d. [	Date signe	d (Month,	Day, Year)
			HI	ll <u>-</u>	5		D=	5559		No	u Grapi	DP 2	4, 2004
	10		30. Name and address of person	who completed ca	use of death (Ite	т 23а) (Туре,					- (0)		
			Thomas E. Masle	n, M.D.			Center Dr	,#316;G	reenvel	t, M	D 207	70	
	Sta Registi		31. Date filed (Month, Day, Year) NOV 29	2004	Registrar's Sign	E COLOR	Sparks	/					
		1			*	/	- /						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Carolyn MINNICK NOV 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospice Facility Baltimore Gilchrist If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Sept 13, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 □ M 2 F Months Yrs. 75 1929 Oregon Director 523-70-5768 3 Usual Residence of Decedent 0 10c. City, Town or Location 10a State 10b. County itam 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at Director Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 11620 Little Patuxent Parkway #201 21044 USA Funeral t 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) 5+ Homemaker Own\_Home 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be ould be f Mental } Mildred Howell Apperson Charles Glasgow Robertson Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deparment of Health a Importent: If item 27 is any injury or other tre once. 11810 Gaslight Place Columbia, Maryland 21044 Peter Van Buren Minnick/son MINNICK 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition November 27 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State \*4 ☐ Donation 5 ☐ Other (Specify) 2004 Arundel Crematory Odenton, Maryland 21. Signature of Funeral Service License 22 Name and Address of Facility Going Home Cremation Service P.O. Box 784 Bevery L Harthe MO1251 Beverly L. Heckrotte, F.A. C. 23a. Part1. Enter the discussion of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MO1251 beverly L. Heckrotte, F.A. Clarksville, MD 21029

Physician /Medical Examiner

> -burialphysician

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Immediate Cause (Final disease or condition resulting in death)

Squamous Cell
Due to (or as a consequence of): Cell Cancer Due to (or as a consequence of): Due to (or as a consequence of):

Approximate Interval Between Onset and Death Years

10:35 PM

Cahty

10d. Inside City Limits

1 ☐ Yes 2 ☑ No

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No

2 No

3 Probably 4 □Unknown

Year

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Rother (Specify) No. c

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death

1 atural 2 Accident 3 Suicide 4 Homicide

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

24a. Was an

autopsy performed? 1 ☐ Yes

28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29c. License number

29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier son wiston

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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Nov. 25, 2004

WBlack 31. Date filed (Month, Day, Year)

NOV 3 0 2004

6601 Norm Charles ST egistrar's Signature

Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** NOVEMBER 23 2004 EVAN K. McLAUGHLIN /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cheverly

There 1 Year If Under 24 Hrs. Min. 8. Date of Birth (Month, Day, Year)

1 192 Prince George's Prince George' Hospital Center If Under 1 Year If Under Months Days Hours Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months **™** M 2□ F 577-34-6977 76 Washington, DC JAN 11 1928 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23a or 28a-f ehow the Medical Exampler must be notified at No Yes 2 No Maryland Prince george's Hyattsville Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20782 5008 37th Avenue USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? My Yes 2 No HYes, Give 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married White 1 Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates: Specify: Specify: þ 3 Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cook Food/Restaurant 12 Health and Mental Hygidem 27 is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ed bluods Hugh D. McLaughlin Floy Southworth McLaughlin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2.
Department of Health at Important: If item 27 is eny injury or other trau John E. McLaughlin (Son) 6079 Sarvis Ave Riverdale, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Cremation 3 □Removal from State Metropolitan Crematory 11-26-04 Alexandria, VA 4 □ Donation 6 □ Other (Specify)

21. Signature of Ineral Service Ligensee 22. Name and Address of Facility M00173 Eberwein Funeral Services Lem 4433 White Pls. La. White Pls., MD 20695 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nediate Cause (Final 2day C **Physician** Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner obstructive among freeze Advanced - gravic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed burial-transit Due to (or as a consequence of): Box 68760. the attending physician Physician/Medlcal as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year signed by the atte in the past 12 months? 5 Other (specify) ☐Yes 2☐No P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Division of Vital Records, 1ÆYes 2□No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy 1 Yes 2 No in by the tuneral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ۵ SiU 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred s after death. 27. Manner of Death Certification: 5 Pendina 1 Natural 2 Accident М 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 T Homicide ō 24 hours a tilled Hospital 1/2 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ş the within 7 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 Ded 52 488 MO ujuas 111a 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Internalmediene dept. MAYADA ISSA RHC 32. R. distrar's Signature 31. Date filed (Month 2 9 State 2004 Registrar

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aryland A should be filed and Mental Hygi marked other umatic event, it	To Be (	17. Father's Name (First, Middle, Last)  Irving Jones	one Grind	TOP AA-III		Joseph	Wallace		
		19a. Informant's Name/Relationship (Ty Alexander H. Park	er/HUsband	5170	ng Address (Street a		umbia, M	D. 21044	
Deficiency of the populary or other north of them more of them to the populary or other pages.		20a. Method of Disposition  1  Burial 2  Cremation 3  F  4  Donation 5  Other (Specify)	lemoval from State	cemetery, crei	osition (Name of matory or other place itan	11-2	Date 4-04	20c. Location - C Alexandr	ity or Town, State
permit. Page Dep riment Important: If any njury or		21. Signature of Funeral Service Licens	hall		2. Name and Addres 217 9th.		shall's	Funeral	Home
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he Hospital n 24 hours he Funeral I	edical	29a. Certifier 1 Certifying Physical Check only one) 2 Medical Examination	sician: To the best of my kn ner: On the basis of examinand manner stated.	owledge, death ation and/or in	occurred at the time vestigation, in my op	e, date and place inion, death occu	e, and due to the curred at the time, d	ause(s) and mann late and place, and	er as stated. d due to the cause(s)
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S Regis	tate / trar	31. Date filed (Month, Day, Year)  NOV 2 9 2004	32. Registrar's Sign	ature	<i>y</i> .				

State of Maryland / Department of Health and Mental Hygien [ ] [ ] Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 22, **Physician** Month November James F. Peake, II 2004 7:16 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hillsboro Caroline 22008 Main Street If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year 9-29-1946 Birthplace (State or Foreign Country) **Funeral** 58 Yrs 212-46-2811 Director Maryland Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28e-f show the Medical Examiner must be notified at Hillsboro Caroline 1 Yes 2 No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23e 21641 USA 22008 Main Street Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No If Yes, Give Year or Dates: 1966-70 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Specify: þ 3 Widowed 4 Divorced "neturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Carpenter Carpentry olth and Mental Hygie 27 Is marked other r treumetic event, It permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth any lighty or other treumetic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Roy Peake Emily Garner Holland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22008 Main Street, Hillsboro, MD 21641 Marcia A. Peake/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Anne's Cemetery 11-24-04 Annapolis, MD ' 4 □ Donation 5 □ Other (Specify) 21. Signature of Foneral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) heet and Death Pnysician (900 /Medicat Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of) or Attending Physicien: The law requires that the death certificate be executed burial-transit attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical JF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1□ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 🗆 Yes Other. 4 Nursing Home 5 Pesidence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this iours after death.

nerel Director: After this filled in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David H. Smith, 29466 Pintail Dr Easton, MD 21601 M.D 32. Resistrar's Signature 31. Date filed (Month State NOV 2 4 2004 Registrar

Physici	an	1. Decedent's Name (First, Middle, Last						2. Date of De	ath	5, 2004	3. Time of Death 14:30
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Examir	ier	Chester River Hos		:		sterto			Ke	ent	
Funeral Director		220 20 2702	x 7. Age (In y	rs. last birthday) 73 Yrs.	If Under 1 Months		Jnder 24 Hrs ours Min		th ly, Year) 19:	Co	nplace (State or Forei untry)
* #		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	ocation						10d. Inside City Limit
i sho	tor	MD Kent	F	Rock Hal	1						1 ☐ Yes 2 📉 N
3a or 28a at be rud	al Director	10e. Street and Number 22772 Colonel Leo	nard Road	_	10f. Zip 0				10g. Citi: USA	zen of What Co	untry?
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23s or 28s-f show my righty or other traumatic svent, the Moutral Exacultation and Legical Bods. Annual Since.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:		Was Decede If Yes, specif 1 Yes 2		nic Origin? (Sexican, Puer Decify:	Specify Yes or No rto Rican, etc.)		4. Race - Ame Black, White Specify: Wh	e, etc.
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page 2 should b	Completed							24a. Was autop perfo 1  Yes		24b. Were aut prior to c death? 1 🗆 Yes	copsy findings availa ompletion of cause of 2 No
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within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe		reet, factory,	office		28f. Location (3 City or Tox	Street and vn, State)	Number or Ru	ral Route Number,
24 hours se Funera sletely fille	edical (	29a. Certifier (Check only one) 1 Certifying Phyone 2 Medical Exam	vsician: To the best of my iner: On the basis of exam and manner stated.	knowledge, deat nination and/or in	h occurred a vestigation, i	t the time, d in my opinio	ate and plac n, death occ	e, and due to the urred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
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Kevin D. Reese 04-7795 DOS

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		1. Decedent's Name (Firs.	. Middle, Las	st)		Ce	rtificat	e of	Death		2. Date of D	Reg. Ne		4	3. Time of Death
Physic /Medi				D. R	eese						Month Decem	nber Da	3, 20°	<sub>9ar</sub> 04	1750p
Exami		4a. Facility Name (If not in Johns Hopk						Town, o	Location C	of Death		4c	. County of	Death	
Funeral Director		5. Social Security Number 219-92-43	54 1	ex MM 2□F		yrs. last birthday 39 Yrs.	Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B	irth Pay, Year)	5 9	Birthpi Coun Mar	ace (State or Forei ry) yland
fand wo		Usual Residence of Dece- 10a. State 10b.	dent County		10	c. City, Town or L	ocation							10	d. Inside City Limi
Mary a-f sh	tor	MD	Harf	ord		E	dgew	boc							1XYes 2□N
with the 3s or 28	I Dire	10e. Street and Number 1304 Clove	er Va	lley W	Vay	Apt.		Code 21	040			10g. Ci	tizen of Wha		try?
5-UUSO 72 hours after deeth with the Maryland natural', or items 23a or 28a-f show afted Examiner must be notified at	/ Funeral Director	11. Marital Status 1 Never Married 2	_	12. Was Dec Armed Fo 1 Tes If Yes, Gi	orces?	in U.S. 13.	Was Dece If Yes, spe				cify Yes or N Rican, etc.)	0-	14. Race - Black, Specify:		
hours tural',	ed by	3 □ Widowed 4 📆 D		Year or L	Dates:	162 Dece	dent's Usu			·		165 K		Whi	
ithin 72 hours after ne man "natural", or Madical Exam	Completed	(Specify onl		de completed)	(1-4or 5+)	(Giv	DO NOT u	ork doné ise retired	during mos d)	st of worki	ng		ind of Busin		•
d Z Z Z filed within Hygiene. rther than "		17. Father's Name (First,	Middle, Last)				Pe	aint		er's Name	(First, Middle		inti:	ng	co.
d be i	To Be	Albert									h A.				
Maryiand  of 2 should be file thand Mental Hy  rismarked oth riraumatic event	-	19a. Informant's Name/R				19b. Mail	ing Addres	s (Street	and Numb		I Route Numi			te, Zip	Code)
and 2 alth a		Ruth A. S	tough	Mc	other		Spru			Ne	ew Ox:	ford	l, PA	17	350
DESILIMOTE, MATYISTIC ZIZIO-0050 permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Madical Examinat must be notified at once.		20a. Method of Disposition  1 Burial 2 Cref  4 Donation 5 C  21. Signature of Funeral	nation 3 other (Specify	1)		Ob. Place of Disp cometery, cre cremati	on Di	irec	t Se	MYE.	RS-Dui	4 BORI		k, UCRA	
u uule au	H	23a. Part1. Enter the dise	, , ,	plications that	viltor	doub Do not or	11 W	IIIIS			JESTMI		ER, 11	IV	Approximate
Physician /Medical Examiner cian and privat-Itansit	Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list condition if any, leading to immediate cause. Emar Underlying Cause (Disease or injury that initiated events resulting in death) Last	s, te	Due to  Due to  C.	(or as a co	nsequence of):	and (	Coca	ine I	ntoxi	lcation	1			
death certificate to a attending physic d for use as the b	by Physician/Medical	IF FEMALE: 23b. Was decedent pregrint the past 12 month 1 Yes 2 No 9 Unknown			birth 2 nant at time	Fetal death 3	⊒Ectopic p ⊒ Other (s)						23d. Date o Month		y Day Year
es that the igned by the	by Ph	Part II. Other significant	conditions o	ontributing to c	death but no	ot resulting in the	inderlying o	ause giv	en in Part I						cause of death?
Vical necolos, sician: The law requires to certificate has been signe irector, page 2 should be o	Completed										24a. Was	s an	24b. Wer	e autop r to com th?	bly 4 Unknowsy findings availabilities of cause of
VICALIT vician: Th certificate rector, pag	Bec	25. Was case referred to examiner?	medical								(Check only				
Physic Physic r this co	은	1 XYes 2 No 27. Manner of Death				2 ER/Outpatie	_				ne 5 🗆 Res 28d. Describe			Specity,	
after and	Certification;	1 Natural 5 2 Accident 3 Suicide 6 5	Pending investigation Could not be determined	12/3 28e. Place	e of Injury -	5:30 At home, farm, s	РМ		k?` Yes <b>X</b> X	No	unk			K Rural	Route Number, 1 <b>zern</b> e Av
safte of in the policy	Serti	4  Homicide		SCC	ding, etc. (S	pecity)				l I	Baltimo	own, State	# 106 . MD	IN LI	izerne av
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the tu	edical (			ysician: To the	e best of m	y knowledge, dea mination and/or i				nd place, a	and due to the	cause(s)	and manne		
To the within 2 To the comple	Me	29b. Signature and title of	certifier 1.	Mnl	102	m	29	c. Licens	e number E				te signed (M mber 5		-
		30. Name and address of	person who	completed cau	se of death	(Item 23a) (Type		Penn	Stre	eet,	Baltim	ore,	MD 21	201	
		1 /= 1<	-111	1 2 0										-	

			1 _ Stata	ate of Maryland /		ment of H		nd Me		20	04	201.	25
			Registrar  1. Decedent's Name (First, Middle, Last)		Certin	icale of L	Jealii	12	Date of Deat		U 14	394	
п	Physici	an	William Edward Rowan						Month	Day	Year	3. Time of	
+	/Medic Examin		4a. Facility Name (If not institution, give street		4h	. City, Town, or	Location of		Vovembe	4c. Count		9:47	- м
	Exami	ei	Montgomery General H		12	Olney	Location of	Douth					
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. last bi		Under 1 Year	If Under 24		Date of Birth		tgome 9. Birthp	face (State o	or Foreign
	Director		053-18-4247	□ F 79	Yrs.	onths Days	Hours	Min. Fe	(Month, Day,		Cour	York	
	pu *		Usual Residence of Decedent  10a. State 10b. County	10c. City, Tov	um as Laureia								
	shor	'n	Tod. State	Toc. City, Tov	WIT OF LOCATIO	on .					1	0d. fnside Ci	ity Limits 2√∑ No
	the M	Directo	Maryland Montgome:  10e. Street and Number	ry Sil	ver S								
	with e or			Dardens 3		Of. Zip Code				0g. Citizen of	What Cour	ntry?	
	ns 23	era	3701 International  11. Marital Status 12. Wa	as Decedent Ever in U.S.		20906 Decedent of His	enanie Origin	in? (Specifi		USA	ce - Americ	an Indian	
92	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show apprintly or other traumatic avant, I're Michal Evartinar maint be notified at once.	/ Funeral	1 ☐ Never Married 2 ☐ Married 1.3	ned Forces? ]Yes 2 ☐ No	If Yes	s, specify Cubar	Specify:	Puerto Ric	an, etc.)	Bla	ck, White, <sub>y:</sub> Whit	etc.	
21215-0036	hours tural',	ed by	3 <sup>™</sup> Widowed 4 Divorced Ye  15. Decedent's Education	ar or Dates: 1943-02		s Usual Occupa							
15	in 72	Completed	(Specify only highest grade comp	pleted)	(Give kind	of work done di NOT use retired)	urina most c	of working		16b. Kind of B	usiness/in	austry	
212	d with giene	Eo	12	llege (1-4or 5+)	nief P	etty Of	ficer			United	Stat	es Nav	7 <b>V</b>
b	al Hyllothe	Вес	17. Father's Name (First, Middle, Last)				18. Mother's	s Name (F	irst, Middle, N				
Maryland	Ment Ment Marked	To	James Luther Rowan						rgaret				
Mar	12 sh and 7 Is m		19a. informant's Name/Relationship (Type, Pr.			ddress (Street a							
e, 1	1 and tealth		Joseph Martin Rowan/B 20a Method of Disposition	rother 12	207 S.	Thomas	Stree	et, A	pt. 22	. Arli	ngton	. VA 2	2204
סר	Se = 50		1 XBurial 2 ☐ Cremation 3 ☐ Remova	I from State Arli	ny cremator	Nation		cembe	er 9,	20c. Location			
altimore,	artmel artant ortant njury		* 4 □Donation 5 □Other (Specify)  21. Signature of Funeral Service Licensee		emete	ry	4	2004		rlingt		irgini	.a.
Ba	Depa Impo any ir		Viller EBou	g	Fran 500	me and Address C1S J. Univers	Collin ity B	ns Fu lvd,	neral N	Home Inver Sp	nc. ring,	MD 20	901
Г			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one caus	s that caused the death. Do se on each line.	not enter the	e mode of dying	, such as ca	ardiac or re	spiratory arre	st,		Approximate Interval Bety	ween
	Physician		Immediate Cause (Final disease or condition A	rteriosclerot	ic Ca	rdiovas	cular	Dise	ase			Onset and D Years	<b>Jea</b> th
	/Medical Examiner			Due to (or as a consequence									
		P.	Sequentially list conditions, if any, leading to immediate	Oue to (or as a consequence	of):								
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		,								
ó	an an rial-tr	Еха	and the state of t	ue to (or as a consequence	of):								
8760,	ficate be executed physician and s the burial-transit	dicai	d										
9	artifica ing ph e as t		IF FEMALE:										
Вох	death certifii attending p	lan/	in the past 12 months?	es, outcome of pregnancy Live birth 2  Fetaf death		pic pregnancy					te of delive	-	ear .
o.	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physiclan/Me		Pregnant at time of death Unknown	5 LI Oth	er (specify)						,	
۵.	that ned by deta	by Ph	Part if. Other significant conditions contributing	ng to death but not resulting i	in the underl	ying cause giver	n in Part I.		23e. Did toba	acco use cont	ribute to th	e cause of de	eath?
Records,	w requires been sign should be								1 🗌 Yes	2 🖾 No	3 Proba	ably 4 □U	inknown
000	aw requas been 2 should	ompleted							24a. Was an	24b. <sup>1</sup>	Were autop	sy findings a	available
ž	0 5 5	Com							autopsy perform 1 Yes 2	ed?	orior to con death? 1 ☐ Yes	npfetion of ca 2 □ No	luse of
Vital	Physician: The this certificate ral director, pag	Bec	25. Was case referred to medical examiner?				26. Place of	f Death (C	heck only one				
	S S D	2	1 ☐ Yes 2 XNo Hospita	1 ☐ Inpatient 2 ☑ ER/O	utpatient 3	□ DOA Other	4 🔲 Nursi	ing Home	5 Resider	nce 6 Oth	er (Specify	)	
Division of	ding Ph. h. After thi funeral	on:	1 XNatural 5 Pending		Time of Injury	28c. fnjury a Work?			Describe hov	v injury occuri	red		
S	r Attending er death. ractor: After by the funer	icat	2 Accident investigation 3 Suicide 6 Could not be	Disea of lainer Ahhara (	N		es 2 □No		1				
<u>≥</u>	Pir Dir	Certification:	4 Homicide determined	Place of Injury - At home, fa building, etc. (Specify)	am, sn <del>ee</del> t, i	actory, onice		201.	Location (Stre City or Town,		er or Hurai	Houte Num	er,
	Hospital		29a. Certifier 1 🔀 Certifying Physician:	To the best of my knowledge	e, death occ	urred at the time	, date and r	place, and	due to the car	use(s) and ma	inner as sta	ated.	
	1 H 2 4 4 H 1 H 1 H 1 H 1 H 1 H 1 H 1 H 1 H 1	edical	(Check only 2 Medical Examiner: Q	the basis of examination and manner stated.	nd/or investig	gation, in my opi	nion, death	occurred a	t the time, dat	e and place,	and due to	the cause(s)	
,	To the within 2 To the complet	Σ	29b. Signature and title of certifier			29c. License				d. Date signe			
	12.41		Jofan Xhr	umi, n.		D0838	31		No	vember	23,	2004	
	10		30. Name and address of person who complete										
			Benjamin Avrunin, M.I 31. Date filed (Month, Day, Year)	0. 18111 Prin	nce Ph	nilip Dr	ive,	Olney	, MD 2	0832			
	Sta Registr		NOV 2 9 2004	Beneva /	4 1	backs	,						

	an	1. Decedent's Name (First, Middle, and Arthur	Last) Melis:	sa Gabr	iela Ro	artment of the sales of SALES			Date of Dea Month	Day	Year	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, S SHADY GROVE AD	give street and nu	mber)	т	4b. City, Town, ROCKVI	or Location o		DEC.	4c. Coun	004 ity of Death	10:45 P
uneral			S. Sex	7. Age (In yrs.		If Under 1 Year	If Under 2		Date of Birtl	h	GOMER 9. Birth	place (State or Fore
rector		216-69-4675 Usual Residence of Decedent	1□M 20F		Yrs.	Months Days	Hours	Min. A	dr"12	, 2004	Mai	land
show	_	10a. State 10b. County		10c. Cit	y, Town or Lo							10d. Inside City Lîm 1 🖫Yes 2 🗆
r 288-r	Funeral Director	Md Montg  10e. Street and Number			Gaitr	ersbur	g			10g. Citizen of	f What Cou	
Mathe	raiD	9023 Centerwa	na me	#309		208					.S.A	
al', or items 23a or 28a-t show Evaminar must be notified at		<ol> <li>Marital Status</li> <li>Married 2 Married</li> </ol>	Armed Fo	2 <b>20</b> No		Was Decedent of f Yes, specify Cul					ace - Ameri lack, White,	etc.
	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Gir Year or D			1 🔯 Yes 2 🗌 No dent's Usual Occu		Hispa	anic	Speci	Mes	rezuela Kician
r than "natural", the Medical Exe	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		-	(Give	kind of work done  OO NOT use retire	during most	t of working			Dusiness/in	ladstry
other than ent, the Me	е Соп	NO 17. Father's Name (First, Middle, La	ast)			No	18. Mothe	er's Name (F	First, Middle.	NO Maiden Suma	ame)	
rked o	To Be	Gerardo R	Rosales					Deni		areja	,	
Item 27 is marked other other traumatic event, I		19a. Informant's Name/Relationship	· ·	ther)	19b. Mailir 4 9	g Address (Stree	t and Numbe mond	or or Rural R	Route Numbe	r, City or Town Gait	n, State, Zip hersl	o code) burg 44d #20877
Item 2 other		20a. Method of Disposition	sales		Place of Dispo	sition (Name of natory or other pla		Date		20c. Location		
ury g		1 XBurial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spe	ecify)		l Sou	Ls Ceme	tery		/04	Germa	ntow	n, Md
Important: If Ite any injury or of once.	1	21 sign upre of Funeral Service Li	gensie	Men	SA 2	Name and Addr Spowden	ess of Facility Fune Washi	ral	Home,	P A ck	2085 V111	0 e, Md
		23a. Part1. Enter the disease, or co shock, or heart fallure. List or	omplications that only one cause on	caused the deat each line.	h. Do not ent	er the mode of dy	ing, such as	cardiac or re	espiratory ar	rest,		Approximate Interval Between Onset and Deati
sician edical		Immediate Cause (Final disease or condition resulting in death)		Lous Rig	ht Cor	onary Ar	terv					Oriset and Deat
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miner		Sequentially list conditions	Due to	(or as a conseq								
miner	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or mijury	b	(or as a conseq	quence of):							
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are Director: After this certificate has been signed by the attending physician and tilled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification; To Be Completed by Physician/Medical Examin	Cause (Disease of mijury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to  c. Due to  d. 23c. If yes, ou  1 Live t  4 Pregi 9 Unkn  s contributing to d  the led 28e. Place build  Physician: To the texaminer: On the b	(or as a consequence of pregnation of pregnation of pregnation of pregnation of pregnation of the consequence of the consequen	puence of):  puence of):  puence of):  ancy al death 3 [ leath 5 [ sulting in the unit of the content of the co	Deet, factory, office	26. Place ther: 4 Nu	of Death (Carsing Home 286) No 28f	1 Y Y 24a. Was a autop perfor in Y Yes Check only or 5 Residd. Describe h	Mobacco use cor fes 2 No fes 2	Annth  Intribute to t  3 Prot  Were auto prior to co death? 1 Yes  ther (Special urred	Day Year  the cause of death'  pably 4 \( \subseteq \text{Unknown}  posy findings availa  mpletion of cause  2 \( \subseteq \text{No}   at Route Number,  stated.
are Director: After this certificate has been signed by the attending physician and tilled in by the funeral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical Examin	Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to  c. Due to  d. 23c. If yes, ou  1 Live t  4 Pregi 9 Unkn  s contributing to d  the led 28e. Place build  Physician: To the texaminer: On the b	(or as a consequence of pregnation of pregnation of pregnation of pregnation of pregnation of pregnation of discount of the pregnation of	puence of):  puence of):  puence of):  ancy al death 3 [ leath 5 [ sulting in the unit of the content of the co	Dectopic pregnand Other (specify) Inderlying cause good at 3 DOA 28c. Injury M 1 Ceet, factory, office a occurred at the vestigation, in my	26. Place ther: 4 Nurry at ork? Yes 2 1	of Death (Carsing Home 286) No 28f	1 Yes  24a. Was a autopoper of the control of the c	Mobacco use cor fes 2 No fes 2	Annth  Intribute to t  Intribu	Day Year  the cause of death- bably 4 Unknot  posy findings availating the first properties of cause  2 No  fy)  at Route Number,  stated, o the cause(s)
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			Decedent's Name (First, Middle,)	Last)							2. Date of De	ath		3. Time of Death
	Physici /Medic		Charles	Thomas	San	sing					Month	23	Zoo	1 1600 M
	Examin		4a. Facility Name (If not institution,	give street and number)			4b. City,	Town, or	Location (	of Death		4c. C	ounty of Deat	•
			University of	Mary Land	. ST	<u>`</u>	-	-	nov					
	Funeral		5. Social Security Number 6 216-60-0283	. Sex 7. Ag	e (In yrs. la 50	st birthday) Yrs.	Months Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Feb. 2	th ay, Year) 8, 19	9. Birt	hplace (State or Foreign untry) y Land
	Director		Usual Residence of Decedent								TCD. Z	0, 1)	54 1141	y Lana
	ryland	_	10a. State 10b. County		10c. City	Town or Lo	cation							10d. Inside City Limits
	8a-fs	Director	Georgia Gwinne	tt	Sne1	lvill	_							1 ☐ Yes 2 🛣 No
	with the		10e. Street and Number 2259 Clairmont C	ircle			10f. Zip					USA	en of What Co	untry?
	death with the Maryland ms 23a or 28a-f show final be rediffed at	Funerai	11. Marital Status	12. Was Decedent	Ever in U.S	3. 13.1			ispanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)		I. Race - Ame	ncan Indian,
9	or Iter		1 ☐ Never Married 2 🛣 Married	Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give	No	i i	f Yes, sped 1 □ Yes		n, Mexicar Specify:		Rican, etc.)		Black, White	
003	ural'.	d by	3 Widowed 4 Divorced	Year or Dates:				725					Specify: Wh:	
15-	"nati	Completed	15. Decedent's (Specify only highest	Education grade completed)		16a. Deced (Give	dent's Usua kind of wo DO NOT u	al Occupa rk done d se retired	ation <i>during m</i> os f)	t of worki	ng	16b. Kind	d of Business/	Industry
12	withii iene. than	omp	Elementary/Secondary (0-12)	College (1-4or 5	5+)		er P1					Plumb	ing Co	ntractor
٦	e filed al Hyg othe vent,	Be C	17. Father's Name (First, Middle, La	ist)							(First, Middle			
<u>a</u>	Menta Menta arked	To	John Horace Sans						Edith	ı Est	elle G	raber		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, If we Madical Exactivations to the recitified at once.		19a. Informant's Name/Relationship								Il Route Numb			
	1 and Healtl tem 27		Patricia J. Sans 20a. Method of Disposition	ing/wife	20b. Pla	ace of Dispo	sition (Nar	ne of			Snellv		GA 300 ation - City or	
όμ.	ages ant of th: If it		1 ☐ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spe			metery, crer Arund			e) ¦N :ory¦	Noven 200	ber 29			aryland
Baltimore,	mit. F partme sortar / injur		21. Signature of Funeral Service Lie								n Serv			
ä	permi Depa Impo any ir		Beverly L	Hette	MO12	51 B	ever1	y L.	Heck	crott	e, P.A	. Cla	rksvil	le, MD 21029
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caused by one cause on each li	the death. ne.	Do not ent	er the mod	le of dyin	g, such as	cardiac c	or respiratory a	ırrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Cereb	val	eden	a,	ha	/nia	tion				Oliset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):	. '		•	•				~48 hrs.
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequ	enou of)	uno	ч	hem	ato	ma_	- 0	Λ.	~48005.
	cuted nd ransit	Examiner	that initiated events	c								M		
,092	ite be executed ysician and ne burial-transit		resulting in death) Last	Due to (or as	a consequ	ence of):								
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£ 0x 68	leath certificat attending phy I for use as th	/Me	IF FEMALE:	23c. If yes, outcome	of pregnar	icy				1	1/2	of selection	d. Date of del	ivery
t Bo	death certifics e attending ph d for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	death 3	Ectopic pr Other (sp			1 /	1 Char	JEG )	Month	Day Year
% O.	that the o	hys	9 Unknown	9□ Unknown					5	A	CHOSTA AN	Ψ		
Ś	se ag	by P	Part II. Other significant condition			lting in the u	nderlying c	ause give	en in Part I	100				the cause of death?
Sord	w requires been sign should be	eted	alcohol	Lutoxica	tran					WIN		Yes 2		obably 4 ∐Unknown
JE Sec	G & C/	Completed									24a. Was auto		24b. Were au prior to death?	topsy findings available completion of cause of
al F	n: Th ficate rr, pag		25. Was case referred to medical								1 Yes	2/2 No	1 ☐ Yes	2 No
2	s certi	o Be	examiner?	Hospital:	ant 2□E	R/Outpatier	ıt 3□ D0	Othe			me 5 Resi		□Other (Spec	cify)
101	ng Phy ter thi	n: T	27. Manner of Death	28a. Date of Inju		28b. Time of		8c. Injun			28d. Describe			
Sion	endin eath. or: Af he fur	atic	1 Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could no	tion	04	1700	М	10					sta	
gayed to me	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: Atler this certificate ha completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could no 4 Homicide determin	ed 286. Pir ce of M	ury - At hor c. (Specify,	ne, farm, str	eet, factory	, office			28f. Location <i>(</i> 10109 <sup>T</sup> V	Street and wn, State) Ves Iei	<i>Number or Ru</i> Lgh Dr.	,Columbia,
180	spital ours a neral I		29a, Certifier 1 Certifying	House  Physician: To the best	of my knov	vledge, deatl	occurred	at the tim	ne. date an					MD
Jax	Me Hos	Medical	(Check only 2 Medical En	caminer: On the basis o	f examinati	on and/or in	vestigation	, in my of	pinion, dea	th occurr	ed at the time,	date and p	lace, and due	to the cause(s)
-	To the To the Comp	Me	29b. Signature and title of certifier				290	. License	e number			29d. Date	signed (Monti	
	0		) U.	my A	2- F	Ф.	1	144	176	435	>	11	23/0	4
8	-E0(		30. Name and address of person w	1 4 17	death (Item	23a) (Type,	Print)	ulh	6ve	eve	H.			
	Sta		31. Date filed (Month, Day, Year) NOV 3 0	2004 32. Aggistr	ar's Signat	ure	<i>P</i>	n.						
	Registr	ar	NOVOV	2004	1	S A	22461	ji .						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Dev Year **Physician** November 24, 2004 2:37 A.M. ation of Death 4c. County of Death Elnore Fields Smith-Scott /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street and number) Examiner Cheverly
If Under 24 Hrs. 8. Prince George's Hospital Center Prince George's If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) Funeral Days Min. Months Hours 1 □ M 20XF 56 Director 419-68-6265 Usual Residence of Decedent Wilcox Co., Ala permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumetic event, the Medical Examinar must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits D.C. Washington 1X Yes 2 □ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 405 Division Ave., N.E. # 204 20019 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. African-Yes 2 No Yes, Give 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Š If Yes, Give Year or Dates: American 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
Continuo I Cattering
Hq., U.S. Marine Corps 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) U.S. Government 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Fields Sadie Lyman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 405 Division Ave., N.E., #204, Washington, D.C. 20019 Broadus Scott/Husband 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from State 12/2/04 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet Cem. Washington, D.C. 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility
H.S. Washington & Sons Co., Inc. any shau 4925 Burroughs Ave., N.E., Washington, D.C. 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical a Cardiovascular Disease 3 Yrs Examiner Due to (or es e consequence of): Physician/Medical Examiner physicien end s the bunal-trensit Diabetes Mellitus, Insulin Dependent 10 Yrs. or Attanding Physician: The law requires that the deeth certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖫 Unknown Hypertension Completed by 24b. Were autopsy findings 24a. Was en autopsy available prior to completion of cause of death? Endstage Renal Disease performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Sepsis 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Naturel 5 Pending To the Hoapital or Attanding within 24 hours efter death.

To the Funeral Director: After completely filled in by the fun 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. onel 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Neme and address of person who completed cauled death (Item 23a) (Type, Print) Revathy Murthy, M.D. 31. Date filed (Month, Day, Year) 6130 Landover Road, Cheverly, Md. 20785

**DHMH 16 Rev 6/95** 

State

Registrar

NOV 2 9 2004

2. Registrar's Signature

		ľ	1 - For State Registrar	State of Mary		artment of F rtificate of		and Me		giene	2004	39439
	Physici	an	1. Decedent's Name (First, Middle, Las	"Scroggins				2	Date of Dea Month	Day	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of	of Death		20 4c.	2.006 County of Death	
	LAGITIN					Ch	never1	.V		Pr	ince Ge	orge's
	Funeral		Prince George's H 5. Social Security Number 6. Se	7. Age (In	yrs. last birthday)	If Under 1 Year Months Days		<i>H</i>	Date of Birtl	h		nplace (State or Foreign
	Director		214-30-1152	XM 2□ F	8Yrs.	Monard Bays	1,00,0		/23/19			Álabama
	and		Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town or Le	ocation						10d. Inside City Limits
	Maryl f sho	ō	Prince G	eorge's		Landov	/er					1 XYes 2 ☐ No
	r 28a	Director	10e. Street and Number			10f. Zip Code				10g. Citiz	en of What Cou	untry?
	h with	al D	2368 Vermont Ave	#102		20	785		u	J.S.A	١.	
	deat	ner	11. Marital Status	12. Was Decedent Ever Armed Forces?		Was Decedent of H	lispanic Orig	gin? (Specif	y Yes or No-	. 1	4. Race - Amer Black, White	
36	or It	by Funeral	1 Never Married 2 Married	ty∏Yes 2 ☐ No ffYes, Give		1 ☐ Yes 2€ No	Specify:	, , , , , , , , , , , , , , , , , , , ,	,		Specify:	
Ö	hours ural',	q p	3X Widowed 4 □ Divorced	Year or Dates:							Bla	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show the Medical Ezana er must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most	t of working		IOD. KI	nd of Business/li	ndustry
212	d with giene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	т	ruck Driv	<i>r</i> er				Pr	ivate
פַ	e filec al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Last)			THEN DIE		r's Name (F	First, Middle,	Maiden .		
/lar	uld b Menta arked	To E	Unknown				Nans	ie Sc	roggir	ıs		
Maryland	12 should be filed within n and Mental Hygiene. r Is marked other than raumatic event, the M		19a. Informant's Name/Relationship (7			ng Address (Street						
	l and fealth im 27 her tr	1	Joan Scroggins/ Da		2368 Ob. Place of Dispo	Vermont	Ave.	#102	_			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any riqury or other traumatic event, the Medical Examiner must be notified at ance.		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, cre	matory or other place n Cemetel		.1/30/			cation - City or T Ltenham,	
ij	it. Pa intmer intant njury		'4 □ Donation 5 □ Other Specify  21. Signature of Funeral Arvice Licen	)			-					
Ba	permil Depar Impor any in		21. Signature of 1 united at 1 united at 1			2. Name and Addre						nome
			23a. Part1. Enter the disease, or companies shock, or heart failure. List only	lieations that caused the							20,03	Approximate
	Physician		Immediate Cause (Final	Respire	(X	lin						Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a Due to (or as a co		WO V.						
	Examiner		Sequentially list conditions	sepsis								
	D =	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a co								
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or 's a co	Cercinon	2					-	
8760,	icate be executed physician and s the burial-transit	al E		d Coron		2) (34)	r.M					
687	phys phys s the	dical		d. 03/0/0	v -	2 200						
Box (	death certific e attending p ed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pr		<b>-</b>				2	3d. Date of deliv	/ery
	death e atte	icia	in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time		□Ectopic pregnancy □ Other (specify) _	<i>y</i>				Month	Day Year
P.O.	that the de ed by the detached	hys	9 Unknown	9[] Unknown								
Ś	es be	by	Part II. Other significant conditions of	ontributing to death but no	ot resulting in the u	inderlying cause giv	ren in Part I.					the cause of death?
ord	w requir been si should	ted							1 ∐ Y	es 2L	JNo 3∐Pro	bably 4 TUnknown
ec	S S	Completed							24a. Was a autop	sy	prior to co	opsy findings available ompletion of cause of
E		Co							perfor 1 Yes	med / 2√ No	death? 1 ☐ Yes	2 No
of Vital Record	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth	105		Check only or			
o	Phys r this ral di	1. To	1 ☐ Yes 2 No 27. Manner of Death	1 Inpatient 28a Date of Injury	2 ER/Outpatie	f 28c. Injur	y at		5 ∐ Resid d. Describe h		Other (Speci	1fy)
ion	nding ith. : Afte	tior	1 Natural 5 Pending 2 Accident investigation	(Month, Day Ye	a <i>r)</i> Injury	Wor M 1 □	rk? Yes 2∐N	No				
Division	or Attending after death. Director: After in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, st	reet, factory, office		28f	Location (S City or Tow		Number or Rui	ral Route Number,
	tal or	Cert		bollowing, oto. (b	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				ony or 1011			
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	edical	29a. Certifier 1 Certifying Ph	ysician: To the best of my niner: On the basis of exa	y knowledge, deal imination and/or in	h occurred at the til	me, date and	d place, and	due to the o	cause(s)	and manner as	stated. to the cause(s)
	To the I	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. Licens					signed (Month,	
	To	-	290. Signature and title of certifier	~		200. 200113	D006	61446			122/04	
0	$(\eta)$		30. Name and address of person who	completed cause of death	(Item 23a) /Tuna	Print) Ac.	NCE G		EL LINI		/	
1	( )				TAMAR	CHI	EVERLY,	MA	3001	Hos	CENTE PITAL DR	NE
	Sta	ite	31. Date filed (Month, Day, Year)	Registrar's			-/,	THE WAY		/		
	Regist	ar	NOV 2 9 2004	Bloker	H has	Les .						

			1 - For State Registrar	State of Maryland	d / Depa		Health and N	Mental Hy	/giene Reg. No. ()	0.1	39440
Н	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of D	Day	Year	3. Time of Death
	/Medi		4a. Facility Name (If not institution, give s	Mavis Scan	Ion	4h City Town	or Location of Death	Novemb		2004 unty of Death	12:35 P <sup>M</sup>
	Examir	ner	Genesis Health C				na Park			ie Arun	ndel
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bi			place (State or Foreign
	Director		501-36-9771 1 Usual Residence of Decedent	<sup>™ 2</sup> XF 66	Yrs.	Months Days	Hours Min.	8. Date of Bi (Month, D March	2, 193	38 Nor	th Dakota
	Marylan I-f show	tor	10a. State 10b. County  Maryland Prince G		, Town or Lo	cation Lanha	m			1	0d. Inside City Limits 1 ☐¥es 2 ☐ No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: if Item 27 is merked other than "naturel", or itams 23a or 28a-f show important: if Item 27 is merked other than "naturel", or itams 23a or 28a-f show arriving or other traumatic event, the Madical Examinar must be notified at once.	I Director	10e. Street and Number 6420 Brightle			10f. Zip Code	0706		10g. Citizen	of What Cour	ntry?
	death ms 2	Funeral	11. Marital Status	12. Was Decedent Ever in U.S	3. 13.	Was Decedent of H	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No	0- 14.	Race - Americ	can Indian,
920	urs after al', or ita Examine	ğ	1 ☐ Never Married 2 ☐ Married 3X Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	i	f Yes, specify Cub. 1 ☐ Yes 2🔀 No		Rican, etc.)		Black, White,	
0	72 hou	ted	15. Decedent's Educ	cation	16a. Deced	dent's Usual Occup	pation		16b. Kind o	of Business/Inc	dustry
21	/ithin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)			pation during most of work d)	ing			
2	filed w Hygier thar th	Ö	12th		Cu	stomer S				Privat	e
Maryland 21215-0036	should be find Mental Hamkad of umatic ever	To Be	17. Father's Name (First, Middle, Last)  Gottlieb Pfin	gsten			18. Mother's Nam	e (First, Middle ie Dewe		name)	
	and 2 sho ealth and n 27 is m		19a. Informant's Name/Relationship (Ty), Christine Gendel		19b. Mailir 6 Wi	ng Address (Street ndwhispe:	and Number or Run r Lane, A	al Route Numb nnapoli	er, City or To S, MD	wn, State, Zip 21403	Code)
Baltimore,	Pagas 1 annount of He ant: If Itam arry or other		20a. Method of Disposition 1 ▼Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)			sition (Name of natory or other place		Date		on - City or To	
Ħ	mit. F vartme ortan injur		21. Signatur Funeral Service License				tery 11/3 ss of Facility Ren				
ä	permit. Departr Importa any inji		19 an low 3	Pegel -			polis Roa				
	Physician and /Medical Examiner per private provided the private provided the private	l Examiner	23a. Parti. Enter the disease, or compile shock, or heart failure. List only on the shock of the	Due to (or as a conseque  CVA  Due to (or as a conseque  Seizure  Due to (or as a conseque	ence of):	bolism					Interval Between Onset and Death
. Box 68	death certific e attending pl d for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal o 4 ☐ Pregnant at time of dea 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)	,		23d.	Date of delive Month	ry Day Year
rds, I	w requires that been signed to should be deta	by	Part II. Other significant conditions con	tributing to death but not result	ting in the ur	iderlying cause giv	en in Part I.				e cause of death?
	The la ate has page 2	Completed						24a. Was autor perfo 1 🗆 Yes		b. Were autop prior to con death? 1 ☐ Yes	osy findings available inpletion of cause of
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	ospital:		Cth	26. Place of Death				
	ding Phys h. After this funeral di	tlon; To	1 Yes 2 No 1  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	I Inpatient 2 E	R/Outpatient 28b. Time of Injury	28c. Injun Work	er: 4 Nursing Hol y at k? Yes 2 □ No	me 5 Resident			)
5	in Die	Certification	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (S City or Tov	Street and Nu vn, State)	mber or Rural	Route Number,
	8 4 7 9	edical C	29a. Certifier (Check only one) 1 Certifying Physical Certifying Physical Examination (Check only one)	ician: To the best of my knowler: On the basis of examination and manner stated.	occurred at the tin estigation, in my o	ne, date and place, a pinion, death occurr	and due to the ed at the time,	cause(s) and date and plac	manner as sta e, and due to	ated. the cause(s)	
	To tha within 2 To tha complet	M	29b. Signature and title of certifier	62		29c. License	number		29d. Date sig	ned (Month, D	Day, Year)
	7		MINM	Physicia	in	D005	56950		Novew	ber 29	1,2004
R	(8)		30. Name and address of person who cor	mpleted cause of death (Item 2	23a) (Type, F		1J D-	. 7	D 0110	•	
	Sta	10	Nnaemeka Agajelu 31. Date filed (Month, Day, Year)	, M.D. 8094 E		kaynor B.	lvd., Pas	adena M	n stts	4	
	Sta Registra		NOV 2 9 2004	Elem &	has	W					

			State of Maryland / Department of State of Maryland / Department of Certificate of			iene g. No.	4 39441					
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Ye	3. Time of Death					
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town,	, or Location of Death	November	25, 200						
	Ladiiii		8342 Northbrook Lane Betheso	da		Montgom						
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 82 Yrs. Months Days		8. Date of Birth (Month, Day, 03/26/1	Year) 9.	Birthplace (State or Foreign Country)					
			Usual Residence of Decedent		03/20/1	922	Iran					
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f ahow sumatic event, the Madical Examinations is the notified at	ŏ	10a. State 10b. County 10c. City, Town or Location  Maryland Montgomery Bethesda				10d. Inside City Limits 1 ☐ Yes 2 🛣 No					
	h the h r 28a-	Director	MaryLand Montgomery Bethesda  10e. Street and Number 10f. Zip Code	,	10	g. Citizen of What						
	ath wit 23a c ust be	alD	8342 Northbrook Lane 20814		τ	J.S.A.						
	after death w	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of If Yes, specify Cut	f Hispanic Origin? (Spe aban, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, Vhite, etc.					
036	ours af	by	1 Never Married 2 Married 1 Yes 2 No 3 Widowed 4 Divorced Year or Dates:	o Specify:		Specify:	White					
21215-0036	n 72 hours natural;	Completed	15. Decedent's Education (Specify only highest grade completed)  Florenstant/Specification (12)  College (14 As 5.)  16a. Decedent's Usual Occur (Give kind of work done life. DO NOT use retire	upation e during most of work	ing 1	6b. Kind of Busine	ess/industry					
212	l withir liene. r than	omp	Elementary/Secondary (0-12)  College (1-4or 5+)  Engineer	'ed)		Lucan Es						
De .	al Hyg r other	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, M	Sugar Fac Naiden Sumame)	tory					
Maryland	es 1 and 2 should be filed w of Health and Mental Hygie If Item 27 is marked other ti rrother traumatic event, ID	To	Shoeib Sepehri	Gohar Ya								
	and 2 sh ealth and m 27 is n		19a. Informant's Name/Relationship ( <i>Type</i> , <i>Print</i> )  19b. Mailing Address ( <i>Stree</i> Fatemeh Sepehri/Wife  8342 Northbro									
altimore,	Pages 1 ar lent of Hea nt: If Item ry or other		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)			0c. Location - City						
ij	Page tment tant: It		`4 Donation 5 Other (Specify) Parklawn Mem. Parklawn Mem.	rk 11/28			, Maryland					
Bal	permit. Pages Department of I Important: If Ite any injury or of			ress of Facility Hin								
			26a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dvi				ing, MD 20904					
30	Priysician		shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition	II Cell In	n. Car	rer	Interval Between Onset and Death					
25	/Medical Examiner		Due to (or as a consequence of):	Trock The	8	TCAL!	1.0					
2	100	er	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury				60 years					
3	be executed sician and burial-transit	Examiner	that initiated events									
90,	be exe ician a burial-		resulting in death) Last Due to (or as a consequence of):									
C C C	phys phys as the	edica	d									
Sox	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transi	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy	cv		23d. Date of						
O. E.	he dea	ysici	in the past 12 months?  1  Yes 2 No 9 Unknown  In the past 12 months?  4 Pregnant at time of death 5 Other (specify) _	-,		Month	Day Year					
20.	es that the de igned by the be detached	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause gr	iven in Part I.	23e. Did toba	cco use contribute	e to the cause of death?					
ords	w requires been sign should be	ted b			1 <b>X</b> Yes	2 □ No 3 □	Probably 4 Unknown					
) Jeco	has be	Completed			24a. Was an autopsy	prior	autopsy findings available to completion of cause of					
Fall	ysician: The lis certificate hadirector, page	e Co	25. Was case referred to medical			No 1□Y	1? ∕es 2□ No					
103	ysicia ils cert directo	To Be	examiner?	26. Place of Death then: 4 Nursing Hon			(pecify)					
DYLL VISION of	ng P		27. Manner of Death 28a. Date of Injury 1 X Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) injury 28b. Time of 28c. Injury Wo	ury at 2 ork?	28d. Describe how		223.97					
Sision	Attending r death. ector: After y the fune	ficat	3 Suicide 6 Could not be 28e. Place of Injury - At home farm street factory office	Yes 2 □No	28f Location /Stre	et and Number or	Rural Route Number.					
C.S.	s after s after al Dire	Certification:	building, etc. (Specify)		City or Town,	State)	narar noute reamber,					
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical (	29a. Certifier (Check only and manner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only and manner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	o the	Med	one) and manner stated.  29b. Signeture and title of certifier 29c. Licens		d. Date signed (Mo							
	->-0		I will mo Door	1578910		11/26/	04					
_	`		30. Name and address of person whi completed cause of death (Item 23a) (Type, Print)	11 1	11 000							
	Stat	e.	Day of Tirshteld 10/15 Yern wood Rd, Ket 31. Date filed (Month, Day, Year) 32 Registrar's Signature	thesda, M	14 208,	17						
:	Registra		NOV 2 9 2004 Sparks	/								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month MARY DOROTHY VOVEMBER AUS 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner CHZSTERTOWN

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, ENTER KEN HESTER 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ■ M 2 🗷 F 081 18 Director 113 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. snt: If item 27 is marked other than "natural; or Items 23e or 28e-f show 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked othar than "natural", or Itams 23a or 28a-f show othar traumatic event, If e Madical Examinar must be notified at CHESTERTOWN 1 Yes 2 □ No Be Completed by Funeral Director MD KENT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 204 KOAD ALLE 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 Widowed 4 □ Divorced Specify: WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOME MAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JOHN AVID LOUISE VICTERIA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If itam 27 is any injury or other tra once. 204 CHESTERTOWN = REGORY 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Jeseph's Cemercy | 22. Name and Address of Facility \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee V. FUNERAL WILLIAMS , JA MARVIN V. WILLIAM 205 GREEN HEREN CHESTERTOWN, MO arvin 1 23a. Part1. Inter the disease, or complications that caused in shock, or heart failure. List only one cause on each line. the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician END STAGE ALZHEIM ERS >10 year disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dee to for as a consequence on attending physician and Due to (or as a consequence of): Physician/Medical d. Date of delivery Month Day Year the à cate has been signed page 2 should be det contribute to the cause of death? þ 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ⋈ "No funeral director, Certification: To Other (Specify) ccurred After

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. after death within 24 hours a To tha Funaral D

	d	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ™ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1	23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death
		24a. Was an autopsy autopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No
25. Was case referred to medical examiner?	26. Place of	Death (Check only one)
1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 X Nursir	ng Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death i Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work?  M 1 Yes 2 No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not determine		28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

Medical

(Check only one)

29b. Signature and title of certified

31. Date filed (Month, Day, Year)

KOY 19

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

† Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

ROAD

0041587

29d. Date signed (Month, Day, Year)

CHESTERTOWN

		•	1 - State of Registrar	Maryland / De		ent of H ate of L				giene (	004	391	443
	Dhamini		Decedent's Name (First, Middle, Last)						2, Date of Dea		Year	3. Time of	Death
	Physicia /Medic		DORIS JEAN TRUITT						11	23	2004	17:54	ME
	Examin	er	4a. Facility Name (If not institution, give street and numb	er)	4b. 0	City, Town, or	Location of	of Death			ty of Death	MB	
			5. Social Security Number 6. Sex 7.	Age (In yrs. last birth	day) If U	nder 1 Year	If Under	24 Hrs.	8. Date of Birt		-	lace (State o	r Foreign
	Funeral Director		220-26-3619 1□M X□F	71 Yr	Mon		Hours	Min.	(Month, Da)	, Year)	Coun	LAND,	
	p .		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or I postion								
	faryla shov	5		,							"	0d. Inside Ci 1 🗌 Yes	•
	289-	Director	MD WICOMICO  10e. Street and Number	PARSONS		Zip Code		-		10g. Citizen o	of What Coun		
	with		31425 ZION ROAD				218	49			USA	,-	
	ems 2	Funeral	11. Marital Status 12. Was Deced	ent Ever in U.S.	13. Was D	ecedent of Hi	spanic Ori	igin? (Spe	cify Yes or No- Rican, etc.)	14. R	ace - Americ lack, White,		
36	72 hours after death with the Maryland natural', or items 23a or 28e-f show displ Examiner must be ricitified at	by Fu	1 Never Married 2 Married 1 Yes 2 If Yes, Give 3 Widowed 4 Divorced Year or Date	No		s 2🛛 No	Specify:	,	,	Spec			
21215-0036	2 hour	ed t	3 X Widowed 4 ☐ Divorced Year or Date  15. Decedent's Education	16a, D	ecedent's	Jsual Occupa	ition			16b. Kind of	Business/Ind		
215	within 72 iene. than "nu	plet	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4	(9	Give kind o life. DO NO	work done d Tuse retired,	u <i>ring m</i> os	t of workir	rg g			,	
	e filed within al Hygiene. I other than '	Completed	7		DIST	RIBUTE			1	'IAGAZII		OOK CO	).
Maryland		Be	17. Father's Name (First, Middle, Last)  ROY A. PUSEY						(First, Middle,		ame)		
Ž	2 should and Men is marke aumatic	2	19a. Informant's Name/Relationship (Type, Print)	19b. A	Mailing Add	ress (Street a			I Route Numbe		m. State. Zip	Code)	
	nd 2 salth ar 27 is r trau		LARRY TRUITT - SON						NSBURG,			,	
ore,	es 1 and 2 of Health f Item 27 i		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from St.	20b. Place of D	Disposition crematory	Name of or other place	9)	D	ate	20c. Location	n - City or To	wn, State	
Ĕ	Pages Iment of tant: If it jury or o		'4 Donation 5 ☐ Other (Specify)	LEWIS C					5-2004	VILLARI	DS, MA	RYLANI	)
Baltimore,	permit. Page Department of Important: if any injury or once.		21. Signature of Funeral Service Licensee			and Addres		DOC	JNDS FUI				
			23a. Part 1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each	sed the death. Do no	t enter the	AST MA	IN S'	TREE3	SALISI	BURY, MA	ARYLAN	Approximate	8
	Physician .		Immediate Cause (Final	Mine.	1-	. (	. 1	P	H .	- x		Onset and D	
	/Medical		disease or condition resulting in death)  Due to (or as a consequence of):										
	Examiner		Sequentially list conditions, b.	10	sche	mis	2			0	32	5	
	ed sit	njne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1	0- 1	1	)	*			-Z.V.	P	
	axecul and al-trar	Examine	trial initiation ovorities	as a consequence of)		621(		y co	1012				
8760,	cate be executed physician and the burial-transit	dlcai	d	V				-					
9	ntifica ing ph	Medi	IF FEMALE:						-		- PRIALE.		
Вох	death certifi e attending I id for use as	ian/I	23b. Was decedent pregnant in the past 12 months?	n 2 Fetal death		c pregnancy					ate of deliver	,	/ear
<u>o</u> .	0 0	Physician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregnar 9 ☐ Unknown 9 ☐ Unknown	it at time of death n	5 Other	(specify)						,	
Д.	The law requires that the tee has been signed by the bage 2 should be detached.	by Ph	Part II. Other significant conditions contributing to deal	th but not resulting in the	he underlyi	ng cause give	n in Part I.		23e. Did to	bacco use co	ntribute to the	e cause of d	eath?
rds	w requires t been signe should be								1 □ Y	es 2 🗆 No	3 ☐ Proba	abiy 4 🖰	Inknown
Records,	e law requ has been je 2 shouli	ompleted					_		24a. Was a		. Were autop	sy findings a	
		Con							perfor	med? 2 ☐ No	death? 1 🗌 Yes		
Vital	Physician: Th this certificate rai director, pag	Be	25. Was case referred to medical examiner?			Othe			(Check only or				
o	Phys r this rai dii	To To	1 ☐ Yes 2 ☐ No 1 ☐ Inp 27. Manner of Death 28a. Date of	atient 2 ER/Outp		DOA 28c. Injury			ne 5 Resid			)	
ion	Attending Ph ir death. ector: After th by the funeral	atior	1 ☐Natural 5 ☐ Pending (Month, 2 ☐ Accident investigation	Day Year) Inju	Try M	Work	? ′es 2 ∐ l			,,			
Division	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of building	Injury - At home, fam , etc. (Specify)	street, fa	ctory, office		2	8f. Location (S City or Tow		nber or Rural	Route Numi	ber,
	Hospital or 24 hours afte Funerel Dir tely filled in I												
	To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edical	29a. Certifier (Check only one)  1 Certifying Physicien: To the basis	est of my knowledge, o is of examination and/o r stated:	death occur or investiga	red at the tim tion, in my op	e, date an inion, dea	d place, a th occurre	nd due to the o d at the time, o	ause(s) and r ate and place	manner as sta e, and due to	ated. the cause(s)	i
	To the within 2 To the complet	Me	29b. Signature and title of certifler			29c. License	number	, ,	, 2	9d. Date sign			/
)			1/5/4/0			Da	04	141		11-	23-0	2004	
			30. Name and address of person who completed cause Joseph Kaffello, M.O.	of death (Item 23a) (Ty	ype, Print)	re or	í :	SALIS	bung	Ms			
	Sta Registr			is of examination and/or stated.  of death (Item 23a) (To fine and or fine and	6,	pax	2			_			

				State of Maryland / Depa			•	•	
			1 - For State Registrar		rtificate of		Reg. N	2001.	39446
	<b></b>		1. Decedent's Name (First, Middle, Last,	)		2. D	ate of Death		3. Time of Death
	Physici /Medio		Donald Tousignar	nt		No	vember	<sup>ay</sup> , 2004	6:36 PM M
	Examin		4a. Fecility Name (If not institution, give			or Location of Death		c. County of Deet	
			7051 Carroll Ave		Takoma	-		Montgome	
E	Funeral Director		5. Social Security Number 6. Sec. 12	7. Age (In yrs. last birthday) M 2 F 68 Yrs.	If Under 1 Year Months Days	Hours Min. (N	ate of Birth lonth, Dey, Yea 2 / 29 / 3 (	9. Birti	nplece (Stete or Foreign untry) anaba, Mi.
	p >		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo			., 5,,,,		
	Maryla f ehov	ō	Md Montgor		a Park				10d. Inside City Limits  X☐ Yes 2☐ No
	h with the 13a or 28a.	al Director	10e. Street and Number 7051 Carroll	Ave #209	10f. Zip Code 209	12	10g. C	itizen of What Co USA	untry?
036	72 hours after death with the Maryland natural, or Items 23a or 28a-f show dical Exacting reast be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☑ Divorced	1,□Yes 2 No ± 2 3 1	Was Decedent of Hif Yes, specify Cub.	dispanic Origin? (Specify Y an, Mexican, Puerto Rican, Specify:	es or No- , etc.)	14. Raca - Amer Black, White Specify: W	
2-0	72 ho	eted	15. Decedent's Edu (Specify only highest grad	cation 16a, Dece	dent's Usual Occup	pation during most of working	16b.	Kind of Business/I	ndustry
Maryland 21215-0036	⊆ 3	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) life.	DO NOT use retire	ce Worker	F	ederal	Government
Q 7	be filed withing the Hygiene. d other therework, the Head		12th 17. Father's Name (First, Middle, Last)	FOO	u bervi	18. Mother's Name (First			
an	0 R 7 8	To Be	Thomas Tousig	nant		Cilia L			
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ore	Pages 1 Tent of He Int: If Iter		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	20b. Place of Dispo cemetery, crer	sition (Name of matory or other plac			ocation - City or 1	
Baltimore,	trent:		*4 □ Donation 5 □ Other (Specify)	Riverda				verdale	
Bal	permit. Pages Department of H Important: If Ite any injury or of		21. Signature of Funeral Service Licens		Name and Addre	<sup>ss of Facility</sup> Snead rlakes Pl	Mortu	ary Ser	vice, P.A.
50	A)		23a. Part1. Enter the disease, or compl	ications that caused the death. Do not ent				MICCHE	Approximate
ı	Physician		shock, or heart lailure. List only or Immediate Cause (Final disease or condition	ne cause on each line.		Marid Lahma			Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence of):	tos tout	DOG!	. ) «		
croft,	Examiner		Sequentially list conditions,	o					
	pa is	Examiner	n any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):					
	sicien and burial-transit	хап	that initiated events resulting in death) Last	Due to (or as a consequence of):				_	
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68	ifficati g phy as the								
.О. Вох	requires that the death certificate be executed een signed by the attending physicien and hould be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		Ectopic pregnancy Other (specify)			23d. Date of delik Month	very Day Year
<u>α</u>	that the led by t detach		Part II. Other significant conditions cor	ntributing to death but not resulting in the u	nderlying cause giv	en in Part I. 2	3e. Did tobacco	use contribute to	the cause of death?
ds,	uires r sign	d by				[[	1 ☐ Yes 2		
00	w requir s been s should	ojete				20	ta. Was an	24b. Were aut	opsy findings available
of Vital Record	sician: The law certificate has b irector, page 2 sl	ompieted					autopsy performed?	prior to co	ompletion of cause of
ita		Se C	25. Was case referred to medical			26. Place of Death (Che	Yes 2. N	o 1 ☐ Yes	2□ No
<b>&gt;</b>	Q 50	To B	examiner? 1 Yes 2 No	fospital: 1 Inpatient 2 ER/Outpatien	t 3 DOA Oth	00		6 ☐Other (Speci	
	te.		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injur Wor		escribe how inju		,,
Sio	or Attending ifter death. Director; After in by the funer	cati	2 Accident investigation 3 Suicide 6 Could not be			Yes 2 □No			
Division	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completely filled in by the fur	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office		cation (Street a ty or Town, Stat	nd Number or Rui e)	al Route Number,
	e Hospi 24 hou a Funer letely fill	edicai	29a Certifier 1 Certifying Physical Check only 2 Medical Examin	sician: To the best of my knowledge, death ner: On the basis of examination and/or in- and manner stated.	vestigation, in my o	ne, data and place, and de pinion, death occurred at the	e to the causa(s ne time, date an	d place, and due t	stated, to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	- mo (omi)	29c. Licens		29d. Da	ate signed (Month,	Day, Year)
	7/			- mu (Chris)	DI5	236	1	11/15/04	
			30. Name and address of person who co	impleted cause of death (Item 23a) (Type, which III'S Rockilles Pine)		a to ross			
	Sta Registr	_	31. Date liled (Month, Day, Year)	32. Registrar's Signature	1	,			

State of Maryland / Department of Health and Mental Hygiene) 004 39445 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death November 25 2004 **Physician** Virginia G. Tenney 5:00 P.M. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Friends Nursing Home Sandy Spring Montgomery If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 25,1911 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year Funeral 1□M 2\ F Months Days Hours 166-30-6429 93 Yrs Jan. Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mantal Hygiene. Important: if item 27 is marked other than "netural; or items 23a or 28a-f show any injury or other traumatic event, in Medical Examinet must be notified at once. 10d. Inside City Limits 10a. State 10c. City. Town or Location 10b. County 1 ☐ Yes 2 X No Director Montgomery Gaithersburg 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9226 Bluebird Terrace 20879 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 🖾 No Specify: Specify: White Completed by 3 X Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Physicians Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frank Gemmill Grace Sullivan ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert H. Tenney / Son 9226 Bluebird Terrace, Gaithersburg, MD 20879 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State November 27, 2004 Alexandria, Virginia 22. Name and Address of Facility DeVol Funeral Home, 10 East 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropélitan 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Livens Deer Park Drive, Gaithersburg, MD 20877 RADU 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical MAITIMANI Examiner Due to (or as a consequence of): ATRIAL + IBBILLATION ettending physician and I for use as the buriel-transit The law requires that the death certificate be executed Physician/Medical Exam Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Division of Vital Records. P.O. Box 68760. CONGESTIVE HEART FAILURE Due to (or as a consequence of): resulting in death) Last JN EMIR Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Sick SIANS SANDROME δ ; certificete hes been sig director, page 2 should ! 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ۵ 1 Yes 28 No 27. Manner of Death 28d. Describe how injury occurred Certification: Injury at Work? 1°ENatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 T Homicide TEXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 25 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRIGG CHANEY RJ SILVER SPRING M& 20905 JOHH E-GLAH MD 1731

**DHMH 16 Rev 6/95** 

State Registrar

31. Date filed (Month, Day, Year)

NOV 29

2004

32. Registrar's Signature

			For State Registrar	State of Marylar	-	artment of F			iene •g. No. 2004	39446
ì	Physici /Medic		1. Decedent's Name (First, Middle, Last VIRGIE		YLOR			2. Date of Dea Month Nov.	Day 2004	3. Time of Death 12:15PM
	Examir		4a. Facility Name (If not institution, give  Casey House 5. Social Security Number 6. Se		last birthday)	Rockv:	If Under 24 Hrs.		4c. County of Death Montgor	place (State or Foreign
	Director		Usual Residence of Decedent	<sup>1</sup> M <sup>2</sup> <del>M</del> <sup>2</sup> F 72	Yrs.	Months Days	Hours Min.	May 3	1,1932 Mai	ryland
	he Marylar 28e-f show	ector	MD 10b. County MD Montgor		ty, Town or Lo	ithersbi	ırg			10d. Inside City Limits 1 □ Yes 2 □ No
36	d within 72 hours after death with the Maryland Jiene. r than "natural", or Itams 23s or 28e-f show The Madical Examiner must be notified at	by Funeral Director	460 Girard St1  11. Marital Status  1 Xever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in L Armed Forces? 1 Yes 2 No If Yes, Give	- 1	20	) 8 7 7 ispanic Origin? (Sp an, Mexican, Puerto Specify:		U.S.A.  14. Race - Americ Black, White,  Specify: B13	can Indian, etc.
Maryland 21215-0036	l within piene. r than "	Completed b	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		16a. Dece (Give life.		ation during most of work f)	king	16b. Kind of Business/In	dustry
ryland	2 should be filed vand Mental Hygie Is marked other is sumatic event, II.	To Be (	17. Father's Name (First, Middle, Last)  Basil C. Taylo		10h Marili	Address (Chank	Sarah	E. Ne		0-41
Baltimore, Mai	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 Is marked any injury or other traumatic erons.		19a. Informant's Name/Relationship (7)  Barbara M. Tay  20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Full of the (Specify)  21. Signatur of Funeral Service Licens	Lor-Niece 20b. Removal from State Emp	460 Place of Dispondentery, cree  pry G1	Girard sition (Name of natory or other place COVE CEI 2. Name and Addre	St #103 n   11/2 ss of Facility Sr	Gaith 27/04 nowden	city or Town, State, Zipersburg, Mersburg, Mer	MD 20377  own, State  arg, MD  ome, P.A.
	Fnysician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failufe. List only o Immediate Cause (Final disease or condition resulting in death)	ications that caused the dea ne cause on each line.  ENDSTAGE  Due to (or as a consec	PARI		g, such as cardiac	or respiratory arr		Approximate Interval Between Onset and Death
8760,	ate be executed thysician and the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect Due to (or as a consect Due to (or as a consect d.						
O. Box 6	death certific e attending p id for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12_months? 1 □ Yes 2√2 No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of of 9 ☐ Unknown	al death 3	]Ectopic pregnancy ] Other <i>(specify)</i>			23d. Date of delive Month	ery Day Year
rds, P.	n requires that the been signed by th should be detache	by	Part II. Other significant conditions co	ntributing to death but not res	sulting in the u	ndertying cause giv	en in Part I.		pacco use contribute to the es 2 ⊠No 3 ☐ Prob	ne cause of death? pably 4 □Unknown
al Records,	The law ate has b page 2 sl	Completed						24a. Was a autops perform 1 Yes	y prior to conned? death?	psy findings available impletion of cause of
ion of Vital	Attending Physicien: Thr death. ector: After this certificate by the funeral director, pag	atlon; To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No  27. Manner of Death  12 ☐ Accident  2 ☐ Accident  2 ☐ Accident  2 ☐ Accident	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	28c. Injur Wor	+ □ Nutsing ⊓	ome 5 Reside	e) ence 6XIOther (Specification of the control of t	Hospice
Division	ital or Attendins after deather less bis deathers rel bis by the led in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, str	eet, factory, office		28f. Location (Si City or Town	reet and Number or Rura n, State)	d Route Number,
	To the Hospital or Al within 24 hours after of To tha Funeral Direc completely filled in by	<b>l</b> edical	(Check only 2 Medical Exami	ner: On the best of my known and manner stated.	owledge, death ation and/or in	vestigation, in my o	pinion, death occur	red at the time, d	ate and place, and due to	the cause(s)
į	or To with	M	29b. Signature and title of centifier	the			11218		9d. Date signed (Month,	uay, rear)
			30. Name and address of person who compress that the compression of th	arrison, MD	6001		ter Mill	L Rd Ro	ckville,	MD20850
	Sta Regista		NOV 2 9 20	32. Registrar's Signa	# A	Sparks	/			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Rag. No. U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death NOVEMBER 24, 2004 **Physician** THELERY LEONA MARBRAY THOMAS 12:45P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City, Town, or Location of Death. **Examiner** CHARLES COUNTY NURSING & REHABILITATION CENTER LA PLATA CHARLES If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
OCIOBER 22,1918 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6 Sex **Funeral** 1 ☐ M 2 💢 F Months Days Hours MARYLAND 218-30-4284 86 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heelth and Mental Hygiane.
ant: If item 27 is marked other than "natural", or Items 23a or 28e-f show ury or other treumetic event, the Medical Examinating at must be inclined at 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2▼ No Director BRYANS ROAD MARYLAND CHARLES 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20616 UNITED STATES 6520 FENWICK ROAD Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X No Specify: Specify: BLACK 3 ∰Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) BUILDING SERVICE WORKER-CAFETERIA EDUCATION 12TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ELIZA ELLEN HUNGERFORD MARBRAY MORTON RICHARD J. MARBRAY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dapartment of Heelth ar Importent: If item 27 la any injury or other tret once. THELERY L. THOMAS / SELF 6520 FENWICK ROAD, BRYANS ROAD, MARYLAND 20616 20a. Method of Disposition

14D Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State METROPOLITIAN CHURCH CEM. NOVEMBER 30, 2004 POMONKEY, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) Riture of Fune & Service Lice nsed THORNION FUNERAL HOME, P.A. ADIA C. THORNION JOHNSON MOOS83 3439 LIVINGSION ROAD, INDIAN HEAD, MARYLAND 20640 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Priysician Termina 3 weeks disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and I-transit The faw requires that the death certificate be executed Due to (or as a consequence of): ding physician a Box 68760 Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. | tha 9 Unknown à been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Wasan rox page 2 s autopsy 2 X No certificate 1 ☐ Yes Division of Vital Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 10 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; After 1 Natural 2 Accident 1 ☐ Yes after death. investigation Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel D 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only one) 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 55455 30. Name and add 32. Registrar's Signature 31. Date filed (Month, State Registrar

			1 - For State Registrar	State of Mary	land / Depa	artment of F	leaith and	Mental Hy	giene Reg. N. OOL	39448
	Physici		1. Decedent's Name (First, Middle, Las ROY M. W	" ILLIAMS				2. Date of De. Month NOV .	22 <sup>Pay</sup> 2004 <sup>ee</sup>	3. Time of Death 7:20AM M
	/Medio Examir		4a. Facility Name (If not institution, give PRINCE GEORGE 'S			СН	r Location of Deat EVERLY		4c. County of D	
	Funeral Director		5. Social Security Number 6. Sec. 228 44 4891 11  Usual Residence of Decedent		yrs. last birthday) O Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	NOW 22	y, Y926 34 9. E	Birthplace (State or Foreign Country)
	the Meryland 28a-f ehow officed at	Director	10a. State 10b. County D . C .	100	c. City, Town or Lo WASH	INGTON			10g. Citizen of What	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	23e or	al Dir		ET, S.E. #	<b>‡</b> 5	10f. Zip Code 20(	019		USA	•
900	within 72 hours after death with the Meryland ene. then "naturel", or iteme 23e or 23e-f ehow the Medical Examiner must be notified at	by Funeral	11. Marital Status  1∑ Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1X Yes 2 No If Yes, Give Year or Dates: 1 9 €		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ▼ No	ispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No o Rican, etc.)	14. Race - Al Black, W Specify.BI	
Maryland 21215-0036	permit. Peges 1 and 2 should be filled within 72 hours after death with the Meryla Department of Health end Meniel Hygiens. Importants if Item 27 is marked other then "naturel", or Iteme 23e or 28e-1 ehow arry highry or other traumatic event, it had bedieal Examinational Examinational Examinational Examinational Examinational Examinational Examinational Examination Examinatio	Completed by	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done of DO NOT use retired UNICATI	during most of word)	-	16b. Kind of Busine FED •	
yland	ould be file Mentet Hy arked oth	To Be (	17. Father's Name (First, Middle, Last) WILLIAM H. WI				VIRGI	NIA A.		
Mar	alth end 127 le m r traum		19a. Informant's Name/Relationship (7 FRANCIS WILLIA		1Car	-			or, City or Town, State DALE . MD	
Baltimore,	Peges 1 of Ment of He ant: If Item ury or oth		20a. Method of Disposition  1. ☐ Burial 2 ☐ Cremation 3 ☐  1. ☐ Dogation 5 ☐ Other (Specify	Removal from State		LE CEM.		Date 29/04	20c. Location - City COVESVII	·
Balt	Depart Depart Import any Inj		21. Signature of Funeral Service Liben:	588	3	Name and Address 14t.	ss of Facility h ST., N	ATSON 0	510 <sup>H</sup> •	
760,	Medical Examiner physician of the price of t	Ical Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	//	nsequence of):	C (Hw	cev			Interval Between Onset and Death
.O. Box 68	deeth certifit e attending p od for use es	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of o Month	lelivery Day Year
ords, P	The law requires that the ste has been signed by the pegs 2 should be deteched.	6	Part II. Other significant conditions of	entributing to death but no	t resulting in the u	nderlying cause give	en in Part I.			to the cause of death? Probably 4 Unknown
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of Vital	Ø 10	To Be	25. Was case referred to medical examiner?  1 Yes 2 No		2ER/Outpatien		er: 4 ☐ Nursing H	ith <i>(Check only o</i> lome 5 ☐ Resid	ne) ence 6 □Other(S)	pecify)
	After une	atlon;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	Worl	/ at <br Yes 2 □ No	28d. Describe h	ow injury occurred	
ź	F & F E	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S)		eet, factory, office		28f. Location (5 City or Tow	itreet and Number or m, State)	Rural Route Number,
	To the Hoepital of within 24 hours of To the Funerel D completely filled in	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best of my iner: On the basis of exa- and manner stated.	knowledge, death mination and/or inv	n occurred at the time vestigation, in my of	ne, date and place pinion, death occu	, and due to the or rred at the time, o	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	10-4		29c. License	number	7	29d. Date signed (Mo	nth, Day, Year)
ر ا	90 Fin 1		30. Name and address of person who of	om leted cause of death	(Item 23a) (Type,	Print)	- (3-		NOVEMBE,	24 2004 md
	Sta	te	31, Date filed (Month, Day, Year) NOV 2 9 2004	32. Registrar's S	Signature	al shill	- 000	vens	mony !	
. 54	Registr		NUV 2 9 2004	sever be	good					

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene

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	Dhysis	ion	1. Decedent's Name (First, Middle, Le	st)					2. Date of Deat Month	Day	Year	3. Time of Death
	Physic /Medi		MaryAlice Lorrai	ne Wilson					November	-		1:30 AM
)	Exami		4a. Facility Name (If not institution, giv	e street and number	)			4b. City, Town, or	Location of Death		y of Death	2.50 111
1			Manor Care of Lar	30			1	Largo		Princ	e Geor	rge's
	Funeral		5. Social Security Number 6. S		ge (In yrs. last bir	thday) If U	nder 1 Year		8. Date of Birth (Month, Day, Dec. 2,	Voor)		ace (State or Foreign
	Director		578*84*7947	□M 250F	60	Yrs.	uis Days	riours Will).	Dec. 2,	1943		ngton, DC
	od .		Usual Residence of Decedent									.g.com,
	irylai shov	_	10a. State 10b. County		10c. City, Tow						10	d. Inside City Limits
	Ba-f.	Funeral Director	MD Prince Go	eorge's	Capito	I Heig	hts					14⊟Wes 2□No
	# 52 #	ire	10e. Street and Number			10f	. Zip Code		10	g. Citizen of	What Count	ry?
	15 w	a	1307 Farmindale	Avenue			20743			United	State	9.6
	dea dea	Der	11. Marital Status	12. Was Decedent Armed Forces	Ever in U,S.	13. Was D	ecedent of H	lispanic Origin? (S an, Mexican, Puerl	pecify Yes or No-	14. Ra	ce - Am <i>e</i> rica	n Indian,
2	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hyglene. 7 Is marked other than "netural; or items 23a or 28a-f show treumatic event, the Medical Examination must be notified at		₩⊋Never Married 2 Married	1 ☐ Yes 2 ☐	No		specify Cuba	Specify:	o rican, etc.)		ck, White, e	
8	ours	Completed by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:			- <b>-</b>	Spoony.		Specii	y: Blac	ek
5	72 h	ete	15. Decedent's Ed (Specify only highest gra		16a.	Decedent's U	Jsual Occup	ation during most of wor d)	kina	6b. Kind of B	usiness/Ind	ustry
2	filed within Hygiene. ther than "	du	Elementary/Secondary (0-12)	College (1-4or	5+)	life. DO NO	T use retired	3)				
7	e filed within al Hygiene. I other than ' vent, Ire Ne	ပ္ပိ	12		Hor	nemake:	r			Omest	ic	
밀	be fill d oth	Be	17. Father's Name (First, Middle, Last)					18. Mother's Nan	ne (First, Middle, M	aiden Surnar	n <i>e)</i>	
<u>yla</u>	should be ind Mental i marked o umatic eve	ို	Lee Oliver Wilson	L				Inez D	ew			
a	2 sho and is me		19a. Informant's Name/Relationship (	Type, Print)	19b	Mailing Add	ress (Street	and Number or Ru	ral Route Number,	City or Town	State, Zip (	Code)
≥ _	and all the		Louise Wilson/ Nei	.ce	130	)7 Farı	ningda	le Ave.	Capitol	Height	s, MD	20743
ře	Pages 1 and 2 nent of Health int; if item 27 is ury or other tre	1 3	20a. Method of Disposition		20b. Place of cemeter	Disposition (	Name of	(e)		Oc. Location		
Ĕ	Page ent ent: If ry or		1 🖳 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif			Lincol			1/30/2004	. D.		1 100
Baltimore, Maryland 21215-0020	4 2 2 3		21. Signature of Fugeral Service Liger		TOIC			ss of Facility	1/30/2004	Bre	entwoo	MD , MD
m	permi Deper Impor any ir	b. d						1n Funer				
			schard from		10	3401	B1ade	nsburg R	oad Brer	twood,	MD 2	0722
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	one cause on each i	a the death. Do r ine.	ot enter the r	noae or ayın	g, such as cardiac	or respiratory arre	st,	1	Approximate Interval Between
)	Physician /Medical		Immediate Cause (Final								'	Onset and Death
ſ	Examiner		Immediate Cause (Final disease or condition resulting in death)	<sub>a.</sub> Fata Ca	rdiac A	rhythr	nia				į.	
		_	rosuling in death)		Due to (or as a	onsequence	of):				Ì	
	ed sit	ine		Down Sy	ndrome						1	
	ritificate be executed ng physician and as the burial-trensit	Examiner	Sequentially list conditions,		Dus to (or as a o	onsequence,	of).					
68760,	oe eo		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								1	
87	hysi the t	Medical	that initiated events resulting in death) Last	V	Due to (or as a c	onsequence	of):					
9	ing p	Me		_							-	
Вох	tendi tendi	an		G								
~	deat he at	sic	Part II. Other significant conditions co	ntributing to death b	ut not resulting in	the underlyin	ng cause give	en in Part I.	23b. Did tob	acco use co	ntribute to t	he cause of death?
<u>Р</u> О	by the	Physician/							1 □ Ye	s 2X□ No	3 Proba	bly 4 Unknown
ري ص	as the	۵	Status post Right	Hip repl	acment,	severe	oste	oarthrit:	is			
Division of Vital Records,	law requires that the death cer as been signed by the attendin 9 2 should be detached for use	ᄝ							24a. Was an	autopsy	24b. Were	e autopsy findings able prior to
ပ္ထ	s bee	Completed							perform	eu r		pletion of cause
ž	The law ete has page 2	E							1□ Vac	ুক্র ১।০		
g	n: T		25. Was case referred to medical					00 Dis. (D.		5.¥ №	- 10	Yes 2□ No
>	sicie cert irect	o Be	examiner?	Hospital:	- 0 T FD/O		DOA Othe	ar.	th (Check only one,			
ō	Phy raid	- L	27. Manner of Death		ent 2 ER/Out		DOA	Xivursing Ho	ome 5 Residen 28d. Describe hov			
<u></u>	After fune	i	XX Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Yeer) Ir	jury M	28c. Injury Work	(? Yes 2 □ No	20d. Dodoribe nov	injuly cocum	90	
S	Attending Physicien: It death. Setor: After this certification by the funeral director.	Certification:	3 Suicide 6 Could not be	28e Place of Ini	ury - At home, far				28f. Location (Stre	et and Numb	or or Purol I	Pouto Mumbor
_	or A efter Direct	Ē	4 ☐ Homicide determined	building, et	c. (Specify)	III, 311 <del>00</del> 1, 140	iory, office		City or Town,	Stete)	er or nurer r	noute ryumber,
_	To the Hospital or Attending Physicien: The k within 24 hours effer death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.		20a Cortifier W Constitution To	elelen. Ta that a	-4 1 1 - 1		and ac at	- d-1 - 1 -				
	Hos 24 hr Fun itely	edlcal	29a. Certifier 1  (Check only one)  1  Certifying Phy  2  Medical Exam	sician: To the best	l examination and	ਹਦਕਾਸ occurr /or investigat	ed at the tim ion, in my op	e, date and place, pinion, death occur	and due to the cau red at the time, dat	se(s) and ma e and place, a	nner as stat and due to th	ed. he cause(s)
	thin the	Mec	29b. Signature and title of certifier	and manner sta	ateu.		29c. License					
	F.3 E.8		A A A A	2/0			D 515		290	Date signed		
	(2)			W			, , U	~~			5-07	
)	(4)		30. Name and address of person who o									
_	U		Bahram Pishdad,			rn Ave	SE #3	310 Washi	ngton, D	C 2003	2	
	Sta		NOV 2 9 2004	. Registr	ar's Signature—	had .						

DHMH 16 Rev 6/95

			1 - For State Registrar	State of Mar	yland / Depa			Mental Hygid	ene 004	39450		
	Physici /Medio Examir	al	4a. Facility Name (If not institution, give	wilso		-	or Location of Deat	2. Date of Death Month November	4c. County of Deat			
	Funeral Director		5/9-36-9600	ex 7. Age (I	lill Rd. In yrs. last birthday) 77 Yrs.		kville If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	Montgon  9. Bin Co 1927 Mass	nery hplace (State or Foreign unity) sachusetts		
	filed within 72 hours after death with the Maryland Hygiene. thar than "natural", or Items 23a or 28a-f show ant, Ite Medical Exprorest roust be notified at	ector	Usual Residence of Decedent  10a. State 10b. County  Md. Montgo  10e. Street and Number		oc. City, Town or Lo	nery Vill	age			10d. Inside City Limits 1 □ Yes 2 ☑ No		
	death with ms 23s or	<b>Funeral Director</b>	19514 Divot Pla	12. Was Decedent Eve	er in U.S. 13.	10f. Zip Code Was Decedent of I	20886 Hispanic Origin? (S an, Mexican, Puerl		United S	States		
9000	hours after tural', or ite	ed by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		1 □ Yes 2 KNo	Specify:		Black, White	e, etc. White		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic avant, Ite Modest Examinat must be notified at once.	Completed by	15. Decedent's E. (Specify only highest gra	de completed)  College (1-4or 5+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retire Kkeeper	during most of wor	rking	Bb. Kind of Business/	Industry		
ryland	hould be fil d Mental H narkad oth natic avan	To Be	17. Father's Name (First, Middle, Last)  David Carra  19a. Informant's Name/Relationship (	ıway	40h Maili		Effie	Kenne	dy			
re, Ma	Health an tam 27 is rothar traur		James E. Wilson  20a. Method of Disposition	ı, Jr./Husba	nd 19514	Divot F	Place, Mo	ntgomery '	City or Town, State, 2 Village, No. Location - City or T	1d. 20886		
Baltimore,	ppartment of portant: If i portant: If i i i i i i i i i i i i i i i i i i		1  Burial 2  □ Cremation 3  □ 4  □ Donation 5  □ Other (Specify 21. Signature of Funeral Service Licer	see	Parklawn		/ 12/	1/04	Rockville			
	4.0 E # 9	21. Signature of Funeral Service Licensee  Muriel H. Barber Funeral Home P. 0. Box 5038, Laytons ville, Md. 2088  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Internited in the control of the c										
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. METAS  Due to (or as a co	TATIC BRI	EAST CANO	ER			Onset and Death		
8760,	death certificate be executed e attending physician and of for use as the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate name of the conditions of	b. Due to (or as a co								
O. Box 6	that the death certifica hed by the attending ph detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	Ectopic pregnanc Other (specify)	,		23d. Date of delin	very Day Year		
ords, P.	w requires tha been signed I should be det	by	Part II. Other significant conditions of CEREBROVASCU			nderlying cause gn	en in Part I.		cco use contribute to 2 □ No 3 □ Pro	the cause of death?		
Vital Records,	The law ate has b page 2 s	e Completed	OS Was and others than the					24a. Was an autopsy performe 1 Ves 2	prior to c	opsy findings available ompletion of cause of		
Division of Vit	ding Phys	To B	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No  27. Manner of Death  1 ☑ Natural 5 ☐ Pending investigation	28a. Date of Injury (Month, Day Ye	2 ER/Outpation 28b. Time of Injury	28c. Injur Wor	er: 4 ☐ Nursing H	th (Check only one) ome 5 Residence 28d. Describe how	te 6 Mother (Specinjury occurred	HOSPICE		
Divis		Certification;	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (5	Specify)			City or Town, S				
	To tha Hospital or within 24 hours after To tha Funaral Discompletely filled in	Medical	one)	ysicien: To the best of mainer: On the basis of example and manner stated	amination and/or inv	estigation, in my o	pinion, death occu	rred at the time, date	and place, and due	to the cause(s)		
)	10	_	29b. Signature and the of certifier	He-		29c. Licens	11218	29d.	Date signed (Month), $U/26/\partial$	Uay, rear)		
			30. Name and address of person who charles HARRISON. 31. Date filed (Month, Day, Year)	M.D. 60	001 MUNCA		ROAD, R	OCKVILLE,	MD. 208	355		
	Sta Registr	1		32. Rogistrar's	Signature	Spark.						

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

				Stat	e or Ma	ryland	•	irtment of tificate of	Health and Death	мептат ну	Reg. No.	04	391	+51
Physici	an	1. Decedent's Nam			Uoo	le 1 ove				2. Dete of De Month	er 23,	Year 2007		of Death
/Medi	cal	James 4a Fecility Neme (	A11			k1ey			4b. City, Town, or			y of Death	8:00	) am
Examir	ier	2420 Mumi		-					Silver S	_	1	gomer	У	
° Funeral Director		5. Social Security N 227-56-28	303	5. Sex 1 ☑ M 2 ☐		(In yrs. lesi	birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bin (Month, De March	th Year) 7, 1943	9. Birthp Coun Vir	lace (State try) ginia	or Foreign
ylend		Usuel Residence o 10a. Stete	f Decedent 10b. County		-	10c. City, T	own or Lo	cation				1	0d. Inside	City Limits
e Mar	ctor	Maryland	Montgo	mery		Silve	er Sp	ring						s 2 🖾 No
vith th	Director	10e. Street end Nu						10f. Zip Code 2090	16		10g. Citizen of U.S		itry?	
ne 234	Funeral	2420 Mumi	rord Dri	12. Was	Decedent E	ver in U,S.	13. V		Hispanic Origin? ( ban, Mexican, Pue	Specify Yes or No		ce - Americ	an Indian,	
permit. Peges 1 and 2 should be filed within 72 hours efter death with the Manyland Depermit. Peges 1 and 2 should be filed within 72 hours efter death with the Manyland Deperment of Health and Mantel Hygiene. Important: if Item 27 is marked other than "naturel", or heme 23e or 28e-f ehow withinty or other traumatic event, the Medical Examiner must be notified at ables.	þ		ied 2. Merrie	d 1 □ ` If Ye	ed Forces? Yes 212 N s, Give or Dates:	0	1	Yes, specify Cul		rto Rican, etc.)	Speci	ock, White, of the work of the white, of the white, of the white, of the work of the white, of the w		
72 ho	eted	(Spec	15. Decedent's	Education	eted)	1	6e. Deced	ent's Usual Occu	upation e during most of wo	orking	16b. Kind of E	usiness/Inc	dustry	
within ne.	Completed	Elementery/Seco			ege (1-4or 5-		`life. C Ianag		ed)		Music	Store	/ Pot	o 1 1
Hygie ather the		17. Father's Name	(First, Middle, Le	est)	-		lallag	<u> </u>	18. Mother's Na	ame (First, Middle			/ Ket	атт
Ald be Aentel rked o	To Be	Cecil We	eekley						Mary	Lee Cock	rell			
2 short and N		19a. Informent's N	ame/Relationshi	p (Type, Print	1)		19b. Mailin	g Address (Stree	at and Number or F	Rurel Route Numb	er, City or Town	, State, Zip	Code)	
f end fealth im 27 ther tr		Patricia		kley/W	life	20h Plac	2420 ]	Mumford	Drive; S	ilver Sp	ring, M			906
ages into the rest			Cremetion 3		from State			sition (Name of netory or other pla oln Crem		11/30/04				and
ortant	8	21. Signature of Fu	5 Other (Spe			10.			ess of Facility H					
Deper important		- Dan	W K	N des	Va		113	800 New	Hampshir	e Ave. S	ilver S	pring	, MD	20904
Physician		23a. Pert1. Enter t shock, or hea	he disease, or c art failure. List of	omplications to	that caused on each lin	the death. I			ing, such as cardia				Approxima Interval Be Onset and	ate etween
лиесісат	8	Immediate Cause disease or condition	(Final	0	51	MA-1	C	-Ti /	LUNG	CAINO	FR	1 ;	44	DOTTES
Examiner	L	resulting in deeth)		Θ		Due to (or es								000
ted nsit	edical Examiner			b								<u> </u>		
exacu in and iel-tra	Exa	Sequentielly list co if eny, leading to in cause. Enter Unde Cause (Disease or	enditions, nmediate eriving		ı	Due to (or es	a consequ	uence of):				1		
The law requires that the deeth carificete be executed ste has been signed by the ettending physician and page 2 should be deteched for use as the buriel-transit	Ical	Cause (Disease or that initiated events resulting in death)	5	C		ue to (or as	e consequ	ience of):						
ling pt		resulting in death)	Lusi	d										
deeth certifica	Physician/M									7				
v requires that the de been signed by the should be deteched	hysi	Part II. Other signif	ficant condition	s contributing	to death bu	t not resultin	ig in the un	derlying cause g	iven in Part I.		tobacco use co Yes 2 □ No			Onknown
gned k	by P							-						
equire sen sig	pet										an autopsy ormed?	ava	ere autopsy ailable prior mpletion of	rto
law r hes be	Completed									100.720		of o	death?	Cause
icete		<b>47</b> 111									Yes 2.41%	1	Yes 2	TNo
siciar certif	o Be	25. Was case referexaminer?		Hospital:	1 🗆 Inpatier	1 2∏FR	/Outpatien!	3□ DOA O	ther:	eath (Check only only only only only only only only		ner (Specifi	v)	
Attending Physician: ar deeth. ector: After this certific by the funerel director,	-	27. Manner of Deat	th	28e. I	Date of Injury	/ 28	b. Time of Injury	28c. Inju			how injury occu		7	
endin Beth. br: Aft	atlo	1 Neturel 2 Accident	5 ☐ Pending investiga 6 ☐ Could no	tion			,,		Yes 2□No					
or Att efter d Direct in by	Certification:	3 ☐ Suicide 4 ☐ Homicide	determin	Ad 289.1	Place of Inju ouilding, etc.		, farm, stre	et, factory, office	) =	28f. Location ( City or To	Street end Num wn, State)	ber or Rura	l Route Nu	mber,
To the Hospital or Attending Physician: The law within 24 hours effect deeth.  To the Funeral Director: Affect this certificate hes completely filled in by the funeral director, page 2.	edical C	29a. Certifier (Check only one)	1 Certifying 2 Medical Ex	caminer: On t	o the best of the basis of manner stat	examination	dge, deeth and/or inv	occurred at the t estigation, in my	ime, date and plec opinion, death occ	e, end due to the urred at the time,	cause(s) end m date and place,	anner es st and due to	ated. the cause	(s)
ro the within ro the	Me	29b. Signature and	itle of contifier	-11		0		29c. Licen	nse number		29d. Date signe	ed (Month, i	Dey, Yeer)	
		- fa	uls	Ma	my	Om	D	100	06108	3	Nov. 2	-6,5	2006	7
10		30. Name and edd				•		-	Rockvil	le, Marv	1and 20	850		
Sta Registr		31. Date filed (Mon	th, Day, Yeer)		32. Registre		9	Sporks						

DHMH 16 Rev 6/95

			1 - For State Registrar	State of Mary		artment of			Reg. No 2 0 0	39452
	Physici /Medi		1. Decedent's Name (First, Middle, Last) Barrette Smith		aver	,		2. Date of De Month Novemb	per 25, 200	3. Time of Death 10:51a M
	Examir	ner	4a. Facility Name (If not institution, give s 10710 Jamaica Dri				n, or Location of Dea		4c. County of Do	
İ	Funeral Director		5. Social Security Number 6. Sex 229-16-3502	7. Age (In	yrs. last birthday) 81 Yrs.	If Under 1 Ye Months Da		n. (Month, Da	iy, rear)	Birthplace (State or Foreign Country) irginia
	Maryland	tor	10a. State 10b. County  Maryland Montgo		City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 25 No
	with the	Dire	10e. Street and Number	,	211101	10f. Zip Cod			10g. Citizen of What	Country?
036	be filed within 72 hours after death with the Maryland nat Hygiene. do other then "naturel", or items 23a or 28e-f show event, the Medical Examiner must be rectified at	by Funeral	10710 Jamaica Driv  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Xi Yes 2 □ No If Yes, Give WW Year or Dates:		Was Decedent of f Yes, specify C	of Hispanic Origin? ( luban, Mexican, Pue	Specify Yes or No orto Rican, etc.)	USA 14. Race - Ar Black, W	
21215-0036	vithin 72 ho ne. hen "natur e Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give		ne during most of w ired)	orking	16b. Kind of Busines	
ğ	d be filed within ntal Hyglene. ed other then " s event, the Me	Be	17. Father's Name (First, Middle, Last)		Но	ıse Pair	18. Mother's Na		Self-Emp , Maiden Sumame)	oloyed
Maryland	d 2 should be f th and Mental t 7 is marked of treumatic ever	2	Marvin Weaver  19a. Informant's Name/Relationship (Ty)  Gary M. Weaver / S.				eet and Number or F		er, City or Town, State	
Baltimore, A	permit. Pages 1 and 2 should be Department of Health and Menia Importent: If Item 27 is marked any injury or other treumatic en once.		Gary M. Weaver/S  20a. Method of Disposition  1 Surial 2 Cremation 3 R  4 Donation 5 Other (Specify)	I .	Db. Place of Dispo Cemetery, crea Gate of Cemet	nsition (Name of matory or other p Heaven	Nove	ccle, Will ember 30, 2004	mington N 20c. Location - City Silver Son	
Balt	permit. Departr Imports any inji		21. Signature of Funeral Service License	9000	£ 50	Name and Adrancis Pancis O Unive	dress of Facility J. Collinersity Blv	s Funera d, W, Si	1 Home Inc	
	Pnysician /Medical Examiner	her	23a. Part1. Enter the disease, or complications shock, or heart failure. List only on immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury		Renal [		tying, such as cardi	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death 5 Years
68760,	tificate be executed ig physician and as the burial-transit	ledical Examine	resulting in death) Last	Due to (or as a con	sequence of):					
.O. Box	that the death certifica led by the attending ph detached for use as th	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	3c. If yes, outcome of pre 1 Live birth 2 I 4 Pregnant at time 9 Unknown	etal death 3	]Ectopic pregna ] Other (specify)			23d. Date of d Month	elivery Day Year
rds, P.	sign d be	by	Part II. Other significant conditions con History of Total							to the cause of death?  Probably 4 Munknown
Vital Records,	(0	Completed				-		24a. Was autop perfo 1 Tes	rmed? prior to	
Vita	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 □ No	ospital:	2 ☐ ER/Outpatier	it 3□ DOA	Oth	eath Check onl o	one dence 6 □Other (Sp	
ion of	ding h. After fune	H-	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Time of	28c. In	4   Nuising	7	now injury occurred	eciry)
Division	in B	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - / building, etc. (Sp		eet, factory, office	Ce	28f. Location (S City or Tox	Street and Number or I vn, State)	Rural Route Number,
	To the Hospitel or Al within 24 hours after of To the Funerel Directompletely filled in by	edicai	one)	ician: To the best of my ler: On the basis of exan and manner stated.	knowledge, deatl nination and/or in	occurred at the vestigation, in m	time, date and plac y opinion, death occ	e, and due to the curred at the time,	cause(s) and manner a dato and place, and du	as stated. ue to the cause(s)
)	With Com	W	29b. Signature and title of certifier  Output	Songsto	son. V		ense number 2121		29d. Date signed (Mor	nth, Day, Year) 26, 2004
	1>		30. Name and address of person who con George F. Sengs	mpleted cause of death (			ive, Whea	ton, Md	20906	
	Sta Registr		31. Date filed (Month, Day, Year) NOV 2 9 2004	32. Registrar's S	ignature	Spar	n n			

			1 - For State Registrar	State of	Marylan	-	artmen rtificate					Reg. NZ	004	394	53
ı	Physici		1. Decedent's Name (First, Middle, La MAYBLOSSOM LEV	•	L						2. Date of De Month Novembe	Day	2004	3. Time of 3:20	Death A M
	/Medic Examir		4a. Facility Name (If not institution, giv				4b. City, Gaith		Location o			4c. C	county of De	ath	A
	Funeral Director		5. Social Security Number 6. S 579-44-2323 Usual Residence of Decedent	ex 7. □ M 2 X F	Age (In yrs. I	ast birthday) Yrs.	If Under Months	1 Year Days	If Under : Hours	24 Hrs. Min.	8. Date of Bir (Month Da May 14	th 1904	9. B	rthplace (State o Country) Lorado	or Foreign
	Maryland I-f show	tor	10a. State 10b. County Md. Montgon	nery	_	r, Town or Lo	cation							10d. Inside C	
	with the	Director	10e. Street and Number 11310 Albermyrtle	Road			10f. Zip	Code 20854					ed Sta		
920	hours after death with the Maryland tural', or flems 23e or 28e-f show all Exer. it we must be redified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	12. Was Decede Armed Force 1 Tyes 2 If Yes, Give Year or Date	es? [X] No	1		ent of His ify Cubar	spanic Orig n, Mexican	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	)- 14		erican Indian, ite, etc.	
Maryland 21215-0036	l within 72 iene. r than "na:	Completed	15. Decedent's E. (Specify only highest gra		or 5+)	16a. Deced (Give life. L Admin	kind of wor DO NOT us	k done d e retired)	uring most		_		of Business Scou		
/land	permit. Pages 1 and 2 should be filed Department of Health and Montal Hygi Important: If item 27 is marked other any fillury gs other treumatic event.	To Be C	17. Father's Name (First, Middle, Last, Alfred Crocker Je								(First, Middle, Ba11	, Maiden S	umame)		
	and 2 sho aith and I 27 is me ar treums		19a. Informant's Name/Relationship ( Mary Ellen Polen		r)						Route Number				
Baltimore,	mit. Pages 1 a partment of He cortant: if item injury or oth:		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specifi		110	ace of Dispo metery, cren hany B					<sup>2</sup> 29,		ation - City o	r Town, State	
Balt	permit. Departr Importu any inji	1 3 Donation 5 □Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address of Facility D  10 East Deer Pari										thers		Md. 208	377
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that cau one cause on each	line.	Do not ente	er the mode	of dying	, such as o	cardiac o	r respiratory a	rrest,		Approximate Interval Bette Onset and E	ween
8760,	Medical Examiner  physician and the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (broads or nigny that initiated events resulting in death) Last	b. Due to (or	as a consequ as a consequ as a consequ	ence of):									<b>J</b>
.O. Box 68	death certifii e attending p id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		n 2 ☐ Fetal tat time of de	death 3	Ectopic pre Other (spe					23	d. Date of de Month	•	'ear
s, P	The law requires that the site has been signed by the bage 2 should be detache	þ	Part II, Other significant conditions o	ontributing to deat	h but not resu	lting in the un	iderlying ca	use givei	n in Part I.			obacco use		o the cause of de	eath?
Vital Record	(U	Completed											24b. Were a prior to death?	utopsy findings a completion of ca	available tuse of
	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1 Tyes 2 Too	Hospital: 1 ☐ Inpa	atient 2 🗆 E	R/Outpatient	: 3 DO	Other	-		(Check only o		☐Other (Spe	ecify)	
Division of	To the Hospitel or Attending Physician: within 24 hours after deals after deals for the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	27. Manna of Death  1 Natural 5 Pending  2 Accident investigation  3 Suicide 6 Could not be		njury Day Year)	28b. Time of Injury	28 M	lc. Injury Work 1  Y		2	8d. Describe h				
Δįχ	itel or Att irs after d ral Diract led in by t	Certific	4 Homicide determined	28e. Place of building,	etc. (Specify)						City or Tow	ın, State)		ural Route Numt	oer,
	To the Hospitel or Attending I within 24 hours after death. To the Funeral Diractor: After completely filled in by the funer	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the be liner: On the basis and manner	s of examinati	rledge, death on and/or inv	estigation,	in my opi	nion, death	d place, a	d at the time, o	date and pl	ace, and due	to the cause(s)	
)	2 ₹ 2 5 \O	×	29b. Signature and Mile of certifier	( ) olu	in		1	License 2	number 2014	98				1h, Day, Year) 27, 2	009
	•			olinsky	91	Rus	scl	Ave	. 6	zith	ersbur	9 1	Nd.		
3	Sta Registr	_	31. Date filed (Month, Day, Year)  NOV 2 9 200		strar's Signati	Jre &	Spor	Kal				-4			

			1 - State of Maryland / Department	artment of Health and Martificate of Death	lental Hygier	2001. 20161
	S Physici		1. Decedent's Name (First, Middle, Last)  Kathryn Denese Walz		2. Date of Death Month November	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, give street and number) 5877 Union Ridge Drive	4b. City, Town, or Location of Death Adamstown		4c. County of Death
	Funeral Director		5. Social Security Number 214-52-4712  G. Sex 1 M 2 A F  7. Age (In yrs. last birthday) 57 Yrs.  Usual Residence of Decedent	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yea March 8,	9. Birthplace (State or Foreign Country) Washington, D.C
	a Maryland sa-f show tiffed at	ctor	10a. State 10b. County 10c. City, Town or Lo  Maryland Frederick Adamstown			10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	th with th	ai Directo	10e. Street and Number 5877 Union Ridge Drive	10f. Zip Code 21710	10g. 0 US	Citizen of What Country?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28a-f show entry injury or other treumatic event. If a Marical Eya-iii at must be rectified at once.	by Funeral	I 1 ☐ Never Married 2 ☐ Married I ☐ Yes 2 ☑ No	Was Decedent of Hispanic Origin? (Spi f Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2X No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
Maryland 21215-0036	d within 72 ho piene. r than "natur ine Medical	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of worki DO NOT use retired) Lary	ing	Kind of Business/Industry
and ;	ld be filed ental Hyg ked othe ic event,	To Be C	17. Father's Name (First, Middle, Last)  Carroll Robert Self		(First, Middle, Maide trice Mart	en Surname)
Mary	od 2 shou Ith and M 27 Is mar treumat	-	19a. Informant's Name/Relationship (Type, Print)  George E. Beall/son  19b. Mailir  5877	ng Address (Street and Number or Rure Union Ridge Drive	Al Route Number, City Adamstown	or Town, State, Zip Code) Maryland 21710
Baltimore,	Pages 1 ar nent of Haa nt: If item ? rry or other			sition (Name of natory or other place)  1 Crematory 30, 2	0.1	Location - City or Town, State
Balti	permit. Departm Importe eny inju		Devely I Wollie M01251 Be	.Name and Address of Facility ing Home Cremation verly L. Heckrotte	n Service e, P.A. Cl	P.O. Box 784 arksville, MD 21029
			23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a. Metastatic Breast resulting in death)	er the mode of dying, such as cardiac o	or respiratory arrest,	Approximate Interval Between Onset and Death 7 years
8760, cate be axecuted Wedical Examiner physician and the burial-transit		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):			
Box 68760,	ath certifii ttending p or use as	Physician/Medical		DEctopic pregnancy		23d. Date of delivery Month Day Year
ds, P.O.	requires that the de aen signed by the s nould be detached t	þ	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
Il Recor	The law ate has b page 2 sh	Completed			24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ N	24b. Were autopsy findings available prior to completion of cause of death?
Division of Vital Record	To the Hospital or Attending Physicien: The within 54 hours alter death.  To the Funerel Director. After this certificate completely filled in by the funeral director, pag	Certification: To Be	25. Was case referred to medical examiner?  1	28c. Injury at 2 Work? M 1 ☐ Yes 2 ☐ No	ne 5 Residence 28d. Describe how inj	ury occurred  and Number or Rural Route Number,
	Hospital of Loss Hours af Funerel Distely filled in	edical Cer	29a. Certifier  (Check only 2 Medical Examiner: On the basis of examination and/or inv	occurred at the time, date and place, a restigation, in my opinion, death occurred	and due to the cause(	s) and manner as stated.  In place, and due to the cause(s)
)	To the within 2. To the Complet	Med	29b. Signature and title of certifier	29c. License number D16675	29d. D	ate signed (Month, Day, Year) ember 29, 2004
3)	a2		30. Name and address of person who complete cause of death (Item 23a) (Type, I Wayne Allgaier M.D. 610 9th Avenue Br		la alle a la constante de la c	27, 2007
6.	Sta Registr		31. Date filed (Month, Day, Year)  NOV 3 0 2004  32. Signature	carle	-	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dev **Physician** 8:40AM Pau1 Weiland November 24,2004 /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Charles County Nursing Home & Rehab La Plata Charles 7. Age (In yrs. lest birthday) If Under 1 Year 1 01 Yrs. Months Days 5. Social Security Number If Under 24 Hrs. Hours Min. **Funeral** 6. Sex 12X M 2□ F 8. Date of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) Hours 051-03-0369 Director June 29.1903 Germany Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or items 23e or 28e-f show ury or other traumatic event, the Medical Examinar mast be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No Completed by Funeral Director MD Charles La Plata 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 20646 USA 10200 La Plata Road 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: White Specify. 3 Nidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Restaurateur Coffee Shop 8 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Be unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Linda Keiser/Niece 9095 Elmer Court, La Plata, MD 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition
1 □ Burial 2 ➡ Cremation 3 □ Removal from State 20c. Location - City or Town, State MD Depertment of H Important: If Ite any Injury or ot Brinsfield-Echols Crem.ll/26/04 Charlotte Hall, 4 ☐ Donation 5 ☐ Other (Specify) 22 AREHART-ECHOLS FUNERAL HOME, P.A 21. Signature of Funeral Service Licenses M00945 CH P.O. BOX 567 LA PLATA, MD. 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Immediate Ceuse (Final disease or condition resulting in deeth) /Medical Examiner Physician/Medicai Examiner use es the bunal-transit or Attending Physician: The law requires thet the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last Division of Vital Records, P.O. Box 68760, Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown To the Funeral Director: After this certificate hes been signed completely filled in by tha funeral diractor, page 2 should be de ģ 24b. Were autopsy findings available prior to completion of cause of death? Be Compieted 24a. Was an autopsy performed? 1 - Yes 2 XNC 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4XNursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation aftar death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide Mospital of 24 hours a Funeral D critifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and manner es steted.

| Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Continued in the ceuse | Co 29a. Certifier (Check only one) To the Vithin 2 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) 30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print)
Krishan Mathur, M.D. 3500 Old Washington Rd. Waldorf, MD 20602

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

NOV 2 9 2004

32. Raistrer's Signature

			For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of H	lealth ai Death		giene 0 0 L	39456
	Dhysisi	25	1. Decedent's Name (First, Middle, Last					2. Date of De Month	nath Day Year	3. Time of Death
	Physicia /Medic	al	Doris Ann Young  4a. Facility Name (If not institution, give	atmost and numbers		4b. City, Town, or	Logotion of	Novembe		23:50 P <sup>M</sup>
	Examin	er	Southern Maryla	·	1	Clinton	LOCATION OF	Death	Prince Ge	
	, Funeral		5. Social Security Number 6. Se		(In yrs. last birthday)		If Under 2	4 Hrs. 8. Date of Bir Min. (Month, Da		hplace (State or Foreign
	Director		213-28-9611 Usual Residence of Decedent	73	Yrs.			03-23-1	1931 Mary	/land
	yland		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Be-f s	ctor	Maryland Charles		Waldorf					1 □Yes 2 No
	with the	Funeral Director	10e. Street and Number			10f. Zip Code 20602			10g. Citizen of What Co	,
	ns 23	era	321 Garner Avenu	12. Was Decedent E	ver in U.S. 13.		ispanic Origi	in? (Specify Yes or No Puerto Rican, etc.)	United State 14. Race - Ame	ncan Indian,
9	or Ite	/ Fur	1 ☐ Never Married 2 💢 Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give	n	1 Yes, specify Cuba	n, Mexican,  Specify:	Puerto Hican, etc.)	Black, Whit	e, etc.
21215-0036	tiled within 72 hours after death with the Maryland Hygiene. sther then "neturel", or Items 23e or 28e-f show ent, the Medical Examinat must be notified at	ed by	3 Widowed 4 Divorced  15. Decedent's Edi	Year or Dates:	16a Dece	dent's Usual Occup	ation		16b. Kind of Business/	nhite
7.	in 72 in "ne Modic	piet	(Specify only highest grad		(Give	kind of work done of DO NOT use retired	during most o	of working	Tob. Talia of Dasilless	industry
21	ed with	Completed	12			emaker			Own Home	2
and	ntal Hy ed oth	Be	17. Father's Name (First, Middle, Last)					's Name (First, Middle,		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23e or 28e-f show any injury or other treumatic event, Ite Medical Examinat must be nullified at once.	스	William James Pucker 19a. Informant's Name/Relationship (T)		19b. Maili			ed Ann Hewi or Rural Route Numbe	er, City or Town, State, 2	Zip Code)
Ž,	and 2 salth a n 27 is er trei		Dale Young-husban	i				ldorf, MD	20602	
ore	ges 1 at He If item or oth		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐!	Removal from State	20b. Place of Disponsion Compterly, cree	osition (Name of matory or other plac	1	Date	20c. Location - City or	
Baltimore,	it. Pagintment rtent: njury		<ul> <li>4 □ Donation 5 □ Other (Specify,</li> <li>21. Signature of Funjaral Service Licens</li> </ul>		1-29-2004	Waldorf, M	aryland			
Ba	permi Depa Impo any it		23a. Part 1. Enter the disease, or comp			2. Name and Addres			00004 0150	
ľ	***		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	ications that caused t ne cause on each line	he death. Do not en	ter the mode of dyin	g, such as c	ardiac or respiratory a	rest,	IIIIGIVAI DOLWOOII
H	Pnysician		Immediate Cause (Final disease or condition	CANCI	ER OF	THE 1	LUNG	5-5		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):					
	2 20	Jer	if any leading to immediate	Due to (or as a	consequence of):					
	icuted nd transit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events	s						
8760,	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as a	consequence of);					
687	ficate figures in the first the firs	edica		d,						
Box	death certificate be executed e attending physician and od for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant	23c. If yes, outcome o		∃Ectopic pregnancy			23d. Date of del	
о В		sicia	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4☐Pregnant at ti 9☐ Unknown		Other (specify)		· · · · · · · · · · · · · · · · · · ·	Month	Day Year
P.O.	The law requires that the de ite has been signed by the bage 2 should be detached		Part II. Other significant conditions co	ntributing to death but	t not resulting in the u	inderlying cause give	en in Part I.	23e. Did to	obacco use contribute to	the cause of death?
rds	w requires been sigr should be	ed by	EMPHYSEM A	. PLEW	IRAL E	EFFUS	ION	101	Yes 2□No 3⊠Pr	obably 4 Unknown
eco	e law requ has been je 2 shoul	Completed						24a. Was autop	osy prior to o	topsy findings available completion of cause of
E B		Соп						perfo 1  Yes	ormed? death? 2 No 1 Yes	2□ No
Vita	Physician: This certificateral director, pr	o Be	25. Was case referred to medical examiner?	lospital:	t 2 ER/Outpatie	nt 3 DOA Othe		of Death (Check only o	one) dence 6 □Other (Spe	a;£.ì
1 of		<b>—</b>	27. Manner of Death	28a. Date of Injury (Month, Day					how injury occurred	suy)
sior	Attending For death, Bector: After by the funer	catio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1 🗆 '	Yes 2 □ N			
Division of Vital Records,	in Dir	ertification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, st (Specify)	reet, factory, office		281. Location (S City or Tov	Street and Number or Ru wn, State)	iral Route Number,
_	pite ours erel filled	O							cause(s) and manner as	
	To the Hos within 24 hd To the Fun completely	ledical	one)	ner: On the basis of e and manner state					date and place, and due	
R	Mith To COTT	Σ	29b. Signature and title of certifier	TTENDING	DHUSICIA	29c: License	e number		29d. Date signed (Mont)	n, Day, Year)
-	77 -		30. Name and address of person who c	ompleted cause of de	ath (Item 23a) (Type	Print)				
1	ムの		MUSA MOMOHA	10 8700	CENTRAL	AV # 30	11. L	ANDOV 62	MD 20	785
100	Sta		31. Date filed (Month, Day, Year) NOV 2 9	32. Registrar	's Signature	Coards.				
	Registr	વા		1000						

			1 - For State Registrar	State of Maryland		artment of H			giene 0	04	39457
	ာ		1. Decedent's Name (First, Middle, Last)		_ 151			2. Date of De			3. Time of Death
	Physici		Boston		An	DOCCO	n	Decembe	er 10	2004	9:30 PM
+	/Medio Examir		4a. Facility Name (If not institution, give stre	et and number)	-/-/-	0,0,0	Location of Death			nty of Death	
			2138 Chantilla Roa			Catons			10.100		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. Ia	ist birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	th	Balti:	more place (State or Foreign
	Director		213-30-2361 <sup>1⊠ N</sup>	<sup>2□</sup> F 73	Yrs.	Months Days	Hours Min.	(Month, Da Aug. 15	y, Year)	Coul	ntry)
			Usual Residence of Decedent					nug. 13	, 1931	mary	/Land
	ylan		10a. State 10b. County	10c. City,	Town or Lo	cation				1	10d. Inside City Limits
	Mar P-f s	for	Maryland Baltimore	Ca	tonsv	i 11a					1 ☐ Yes 2X No
	1 the	Director	10e. Street and Number		COHSV.	10f. Zip Code			10g. Citizen o	f What Cou	ntry?
	3a o	0	2138 Chantilla Road			2122	00				, .
	Jeath Tis 2	Funeral		Was Decedent Ever in U.S	. 13.1	Was Decedent of Hi			U.S.A.	ace - Americ	an Indian
<b>′</b> 0	fter c	Fun	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 X Yes 2 ☐ No		f Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)		lack, White,	etc.
ဗ္ဗ	urs a	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1□Yes 2⊠No	Specify:		Spec	ify:	nite
21215-0036	72 hours after death with the Maryland neturel', or Items 23a or 28e-1 show Jical Exar ill set - ust be netitled at	Completed	15. Decedent's Educat	on	16a. Deced	dent's Usual Occupa	tion		16b. Kind of		
75	n" n	ple	(Specify only highest grade of		(Give	kind of work done d DO NOT use retired)	uring most of work	ing	TOD. KING OF	Dusinessylli	udstry
7	I within liene.	E	Elementary/Secondary (0-12)	College (1-4or 5+) 4+		rney			Housin	o & II1	ban Devel.
	e filed within al Hygiene. other than '	BeC	17. Father's Name (First, Middle, Last)			1110)	18. Mother's Nam				Dan Devel.
Maryland	2 should be and Mental is marked of eumatic ever	To B	Boston Fear Anderso	n, Sr.			Magdaler	a Haver	kamp	,	
7	should not marke umatic	-	19a. Informant's Name/Relationship (Type,	Print)	19b. Mailin	g Address (Street a				n State Zir	Codel
Š	od 2 Ith a 27 is		LaRue Anderson (Wi	fe)		Chantilla					
ล์	Health tem 27 other tra		20a. Method of Disposition	20h Pla	ce of Disno	cition (Name of		Date	20c. Location		
20	Pages nent of int: If its iry or o	Ш,	1 Burial 2 □ Cremation 3 □ Rem	oval from State   Gari	netery, cren 11501	ratory or other place Forest	")				,
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Items 23a or 28e-f show any injury or other treumatic event, Item Acid. Exacting a state of aciding at Angle.		<ul><li>' 4 ☐ Donation 5 ☐ Other (Specify)</li><li>21. Signature of Funeral Service Licensee</li></ul>	Vete	erans	Cemetery	12-1	5-2004	Owin s	Mills	, Maryland
Ba	permit. F Departm Importer any injui		OHED	) mooco	Ψį	Name and Address tzke Fune 30 Edmond	ral Home	of Cat	onsvil	le, In	ıc.
			23a Part Enterthe disease or complicat	MOO869	16	30 Edmond	son Aven	ue Cato	nsville	≥, MD	
			23a. Part1. Enter the disease, or complicate stock, or heart failure. List only one of	ause on each line.	Do not ente	er the mode of dying	, such as cardiac	or respiratory ari	rest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Acute	My	ocord	int	Kuty	arch	on	Oriset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseque	nce of):		٨		<b>V</b>		
		_	Sequentially list conditions, b	(050n/	My	Arte	My /	11JCA	H		
	sit ad	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	nce of		0				
	and tran	Examiner	that initiated events resulting in death) Last	5 . 1 . /							
90,	oe ex cian cian	E E		Due to (or as a conseque	nce or):						
68760,	ficate be executed physician and is the burial-transit	edlcal	d								
-	entific ling p		IF FEMALE:								
Вох	teath certif attending I for use at	ian/	23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregnand 1□Live birth 2□Fetal d		Ectopic pregnancy				ate of delive	,
_ _	the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of dea 9□Unknown	th 5 🗌	Other (specify)			"	lonth	Day Year
Р. О.	The law requires that the death certine thas been signed by the attending age 2 should be detached for use and the state of the state o	Physician/M									
ŝ	res ti	þ	Part II. Dther significant conditions contrib		ing in the un	derlying cause giver	n in Part I.				e cause of death?
9	requi	ted	Proportificae	on (A				1 U Y	es 2 No	3 Proba	ably 4 Unknown
O O	has by	ple	4.					24a. Was a	n 24b	Were autor	osy findings available
<u>~</u>	tending Physicien: The leath.  tor: After this certificate hithe funeral director, page	Completed						perform	med?	death?	
Ta	ilcien: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?				26. Place of Death		·		20.10
<b>&gt;</b>	nysic nis ce dire	To	1 ☐ Yes 2 Mo	ital: 1 ☐ Inpatient 2 ☐ EF	R/Outpatient	3 DOA Other	4 Nursing Ho	me 5 X Reside	ence 6 □Ot	her /Specify	·)
0	ng Pl	ü		8a. Date of Injury (Month, Day Year)	8b. Time of Injury	28c. Injury a		28d. Describe ho			,
<u></u>	ath. pr: Af	atlc	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(mains, Eay roal)	ii ijas y		es 2 No				
Division of Vital Records,	r Atte	ti tic	3 Suicide 6 Could not be 4 Homicide determined	8e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	et, factory, office		28f. Location (St	reet and Num	ber or Rural	Route Number,
	tel o rs aft el Di ed in	Certification;		banding, etc. (bpoony)				City or Towr	i, Siate)		
	lospi Thou uner uner	edical	29a. Certifier  (Check only 2 Medical Examiner:	on: To the best of my knowledge	edge, death	occurred at the time	, date and place,	and due to the ca	ause(s) and m	anner as sta	ated.
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director, p	ledi	one)	On the basis of examination and manner stated.	ii and/or inv	estigation, in my opi	nion, death occurr	ed at the time, d	ate and place,	and due to	the cause(s)
	To with	Σ	29b. Signature and title of certifier			29c. License	number	2	9d. Date sign	ed (Month, E	Day, Year)
	.\		1	M		$\Delta$ 3	6776	2	12-13	-2004	
0	(1)		30. Name and address of person who compl								
	0					colm Driv	e Westm	inster,	MD 211	57	
	Sta Registra		31. Date filed (Month, Day, Year) DEC 1 4 200	32. Registrar's Signatur	9 /	span	la la la la la la la la la la la la la l				

		ı	1 - For State Registrar		Maryland /	Depa		of H	ealth a		lental Hyg		2004-	394	58
	Physici /Medio Examir	cal	Decedent's Name (First, Mid-MELVIN     A. Fecility Name (If not institution)		ber)		4b. City, 1		ELSON Location o		2. Date of Dea Month DEC.	10Day	2004 Souply of Death	3. Time of D	
	Funeral Director		3124 GRACEFIEI 5. Social Security Number 030-20-7498	+	. 221 7. Age (In yrs. last b 75	oirthday) Yrs.	SIL\ If Under		SPRIN If Under 2 Hours		8. Date of Birth Month Day 07/0619		9. Birthr	place (State or MA	Foreign
	ne Maryland Be-f ehow	Director		oy GOMERY	10c. City, To									10d. Inside City 1 ☐ Yes 2	
	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28e-1 ehow ha Madigal Exama ar must be indiffied at	Funeral Dire	10e. Street and Number  3124 GRACEFIEI  11. Marital Status  1 □ Never Married 2 ★ Ma	12. Was Dece Armed For	dent Ever in U.S.	13. \	10f. Zip ( 209 Was Decede f Yes, speci	904	spanic Orig n, Mexican,	jin? (Spe	ecify Yes or No- Rican, etc.)	U.	S.A.  Race - Americ Black, White,	ean Indian,	
21215-0036	thin 72 hours af e. en "naturel", or Medical Exem	Completed by F	3 Widowed 4 Divorce	old If Yes, Give Year or Da ent's Education est grade completed)	16	a. Deced (Give life. I	1 Yes 2 dent's Usual kind of work DO NOT use	Occupa k done d e retired)	uring most		ng	16b. Kin	Specify: WH]	dustry	
Maryland 21;	be filed ital Hygi od other event, I	To Be Com	17. Father's Name (First, Middle NATHAN	3	N	1ARKI ADEI	ETING _SON	EXC		r's Name	(First, Middle, I			HING AMSON	
	is 1 and 2 should of Health and Men item 27 le marke other traumatic		MARILYN I. ADI 20a. Method of Disposition	ELSON / WIF	E 31	24 ( of Dispo	GRACEF	FIELI e of	D RD.	APT	221 SI	LVER		MD 209	04
Baltimore,	permit. Pages Department of t Importent: If it any Injury or o		1 🕅 Burial 2 □ Cremation  '4 □ Donation 5 □ Other (  21. Signature of Funeral Service	Specify)	tate	22 22	1EMORI	AL F	PARK s of Facility	SOL	2/2004 LEVINS	ON 8	OLUMBIA, BROS.,		
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to himediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Due to (c	used the death. Doch line.  WST WTIL  or as a consequence	Pau Pau e of):		of dying	, such as o	cardiac o				Approximate Interval Betwee Onset and De	een eath
O. Box 68760,	the death certificate be executed y the attending physician and sched for use as the burial-transit	Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9  Unknown	d	ome of pregnancy th 2 Fetal death	th 3[	Ectopic pre					23	d. Date of delive	ery Day Yea	ar
ecords, P.O.	law requires that the de as been signed by the a 2 should be detached f	þ	Part II. Other significant condit	tions contributing to dea	ath but not resulting	in the ur	nderlying cal	use give	n in Part I.			s 2	e contribute to the	ne cause of dea	- 17
Vital Reco	The transfer age	Be Completed	25. Was case referred to medic examiner?							of Death	24a. Was an autops perform 1 Yes 2	ned?	24b. Were autoprior to cordeath? 1  Yes	npletion of caus	
of	tending Physicath.  tor: After this the funeral dis	Certification; To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pend 2 Accident inves 3 Suicide 6 Coulc	28a. Date of (Month tigation of the mine)	patient 2 ER/C Injury 28b.  Injury 4t home, 1 Injury - At home, 1 Injury - (Specify)	Time of Injury	28 M	c. Injury Work 1 🗆 Y	4 LI NUI	lo	ne 5 Preside 8d. Describe ho	w injury	occurred		r,
Ω	To the Hospital or At within 24 hours effer of To the Funeral Directompletely filled in by	Medical Cer	29a. Certifier (Check only one) Certify 2 Medica	ing Physician: To the ball Examiner: On the ball and manne	pest of my knowledges of examination a	ge, death ind/or inv	occurred a	t the time	e, date and inion, death	I place, a	and due to the ca	use(s) a ate and p	nd manner as st lace, and due to	ated. the cause(s)	
)	withi To the	M	29b. Signature and title of certification of the signature and title of certification of the signature and address of person	IN Kowli	Clubbo N	WS		D3			y Colum		signed (Month, I		74
	Sta Registr		31. Date filed (Month, Day, Yea	Koutrelak	3 11065 gistrar's Signature			atu		PH	y Colun	nd iv	* mo 2	1044	

			For State Registrer		State of N	/larylan		artmen tificate					jiene eg. No.	04	39459
	Physici	an	1. Decedent's Name (		,							2. Date of Dea	th Day	Year	3. Time of Death
	/Medic		Robert Lo									Deamher		2004	12:25 A M
	Examir	ner	4a. Facility Name (If no			r)		_		Location of	of Death		4c. Co	unty of Death	
	Funeral		Union Mer  5. Social Security Num			Age (In yrs.	last birthday)	Balt If Under	1 Year	CE If Under	24 Hrs.	8. Date of Birth	1	9. Birth	place (State or Foreign
L	Director		219-52-53	311	1 X M 2□ F	55	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day MAY 17	; <i>Year)</i> 1949	Cou	rland
	pu ≱ wuo		Usual Residence of Do	ecedent 0b. County		100 Cit	y, Town or Lo	aation							
	Aaryla F sho	ō		Baltimor	re		butus	Cation							10d. Inside City Limits 1 ☐ Yes 2 1 No
	28a-	Director	10e. Street and Number	er				10f, Zip	Code				Oa. Citizer	of What Cou	
	h with	ai Di	5416 H <b>i</b> gh	nridge S	Street				2122	27			USZ		•
	ams (	Funerai	11. Marital Status		12. Was Deceder Armed Forces		.S. 13. \	Vas Deced	ent of Hi	spanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)	14.	Race - Americ Black, White,	
36	s afte	by Fu	1 XNever Married 3 ☐ Widowed 4 [		1 ☐ Yes 2 ₹	No		☐ Yes 2		Specify:	, , , , , , , , , , , , , , , , , , , ,		Sp		ite
9	n 72 hours after death with the Maryland "natural", or Itams 23a or 28a-1 show idical Examinational be nytified at			5. Decedent's E	Year or Dates	:	16a. Deced	lent's Usua	LOccupa	ation				of Business/In	
215	within 72 ene. than "na he Mcdil	plet		only highest gra		r 5+1	(Give life, L	kind of wor OO NOT us	k done d e retired,	luring mosi )			100. 11110	01 04011033111	austry
21	filed withir Hygiene. rthar than ant, the M	Completed	12		2		Ad	minis	trat	ion (	Opera	ations	D	Lego Co	rp.
Maryland 21215-0036	ild be filed lental Hygie kad othar ic evant, II	Be	17. Father's Name (Fin						-			(First, Middle,		mame)	
7	should by	To	19a. Informant's Name	L. Alve	-		19h Mailin	a Address	(Street a			M. Lemba I Route Number		Casta Zin	Codol
	ges 1 and 2 should be filed within 7: It of Health and Mental Hygiene. If item 27 is marked othar than "n or other traumatic evant, the M. of		Brenda Alv				1					Arbutus,		21227	Code)
re,	item other		20a. Method of Dispos	sition			face of Disposemetery, cren	sition (Nam	e of	1				ion - City or To	own, State
20a. Method of Disposition    X   Burial   2   Cremation   3   Removal from State											12/15	5/2004	EL	cridge,	MD
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Fune	ral Service Lice	nsee	~	Ga:	Name and	Addres Kau	s of Facility	Fune	ral Hom	e@Me	adowrio	dge MP, Inc.
			23a. Part1. Enter the	disease, or com	plications that cause one cause on each	ed the death						Flkr r respiratory arr			Approximate Interval Between
	Physician		Immediate Cause (Fir disease or condition		$\mathcal{V}_{\bullet}$	Mr. hat	· tik								Onset and Death
	/Medical Examiner		resulting in death)		Due to (or a	s a consequ	uence of):			<del></del> -					1000
	2,0	je.	Sequentially list condi	itions,	bbue to (or a	s a consequ	uence of):								
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ó	be executed ician and burial-transit		that initiated events resulting in death) Las	st	Due to (or a	s a consequ	uence of):								
8760,	cate be executed physician and the burial-transit	Physician/Medical		•	d										
9	n certific anding p use as t	/Med	IF FEMALE:		220 16 una autana										
Box	atte for	cian,	23b. Was decedent pr	onths?	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant	2 Fetal	Ideath 3 🗌	Ectopic pre Other (spe					23d.	Date of delive Month	ny Day Year
0	that the do	nysi	1 ☐ Yes 2 ☐ N 9 ☐ Unknown	10	9□ Unknown		Jan. 0_	o a for (ope							
S, D	The law requires that the tee bas been signed by the bage 2 should be detached.	by PI	Part II. Other significa	ent conditions	contributing to death	but not resu	ulting in the un	derlying ca	use give	n in Part I.		23e. Did tob	acco use	contribute to th	e cause of death?
ord	w require been sig should b											1 □ Y€	s 2 1	o 3 ☐ Prob	ably 4 □Unknown
Vital Record	law r nas be s 2 sh	ompleted										24a. Was a autops	اد ۷	4b. Were auto	psy findings available inpletion of cause of
E H		Con			,	_						perform	ned?	death?	21 No
Vit	Physician: The this certificate ral director, pag	Be	25. Was case referred examiner?		Hospital:				Othe			(Check only on			
of	Physic this sral di	To To	27. Mann of of Death	, = 5	1 Inpat	jury	ER/Outpatient 28b. Time of		lc. Injury Work	4 LI NUI		ne 5 Reside			")
ion	Attending r death. actor: After by the funer	atio	1 ☑Natural ! 2 ☐ Accident	5 Pending investigation	(Month, D	ay Year)	Injury	М		? 'es 2 □ N	No				
Division	I or Attending Ph after death. Diractor: After th in by the funeral	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined	28e. Place of It	njury - At ho	me, farm, stre	et, factory,	office		2	8f. Location (St. City or Town		umber or Rura	l Route Number,
	Hospital or At thours after of Funaral Dirac tely filled in by			/											
	To the Hospital of within 24 hours a To the Funeral Completely filled in	edical	29a. Certifier 1 (Check only 2 one)	Medical Exer	nysician: To the bes niner: On the basis and manner s	ot examinat	wledge, death ion and/or inv	occurred a estigation,	it the time in my op	e, date and inion, deat	d place, a h occurre	nd due to the ca d at the time, da	use(s) and ite and pla	manner as st ce, and due to	ated. the cause(s)
	To I To I	Σ	29b. Signature and title	1000	1/2			2.0	License			_	j	gned (Month, i	
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	Ψ		30. Name and address	vary	2012-65+	· Uni	1015 tu	Pari	tiva	5	Ba	1timore	mo	712	18
	Sta Registr	-	31. Date filed (Month,		1	trar's Signat	ture	Ann	. /						
			UEU.	1 <b>4</b> 2004	protection of	P	fred.	appea	Kar						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month 2:02 George Donald Boteler, Sr. 7, 2004 4c. County of Death /Medical December 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1100 Meadowbranch Rd. Unit #4 Westminster Carrol1 If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea Dec. 31, Birthplace (State or Foreign Country) Funeral 1⊠M 2□F Director 89 1914 212-10-7698 Mary land Usual Residence of Decedent death with the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28e-f show treumatic event, it a Modical Examinar must be notified at 1 ☐ Yes 2 No Directo Maryland Carrol1 Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1100 Meadowbranch Rd., Unit #4 21158 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. Is marked óther than "natural", or Itel 1 Never Married 257 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Landscape Owner & Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Boteler I George Allan Agnes V. Geer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 siment of Health an G. David Boteler(Son) 466 Silver Ct., Westminster, MD 21158 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) ŏ Department of Important: if any injury or once. Loudon Park Cemetery 12/10/04 Baltimore, Maryland 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner dany leading to him edit cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit the attending physician and Due to (or as a consequence of): P.O. Box 68760. Physician/Medical as the t IF FEMALE i esr 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐ Pregnant at time of death 5 Other (specify) detached been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 🗌 Yes 2 No 1 🗌 Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: To the Hospitel or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my opinion, death occurred at the time, date and place, and due to the Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature a 29c. License number 30. Name and ddress of person who completed cause of death (Item 23a) (Type, Print) Westminster, MD 21157 John Middleton, M.D. Poole Rd. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State gracen 4 2004 DEC Registrar

			1- State of Maryland / Departn Certific	nent of Health and Mocate of Death		200	11, 20	11 0
	Physic	ian	Decedent's Name (First, Middle, Last)	Suite of Beatif	Reg. 2. Date of Death Month	Day Year	3. Time of D	Death
V.	/Medi	cal	Blanche G. Barnes		December		***************************************	a M
The same	Exami	ner		C1 D.		4c. County of Dea		
			102 North Crain Highway Apt 906  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 15	Glen Burnie	O Date of Righ		Arundel	
п	Funeral Director			nths Days Hours Min.	8. Date of Birth (Month, Day, Ye Oct. 7, 1	9. Bi	rthplace (State or country)	Foreign
			Usual Residence of Decedent		000. 7,1	723 116	ar y ranu	
	yland		10a. State 10b. County 10c. City, Town or Location	1			10d. Inside City	Limits
	Mar Maritis	tor	Maryland Anne Arundel Glen Burnie	9			1 Tyes 2	2 <b>M</b> No
	th the	Director	10e. Street and Number 10	f. Zip Code	10g.	Citizen of What C	ountry?	
	death with the Maryland ma 23a or 28a-f show Innel be redified at	alD	102 North Crain Highway Apt 906	21061		U.S.A.		
	ema erm	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was I Armed Forces? 13. Was I If Yes	Decedent of Hispanic Origin? (Spe specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Am		
36	or it	Y.F.	1 Never Married 2 Married 1 Yes 2 No	es 2 No Specify:	, tiouri, oto.	Black, Whi		
21215-0036	hours after tural', or Ite	d by	3 A⊈ Widowed 4 Divorced Year or Dates:				White	
7	"nat	Completed	(Specify only highest grade completed) (Give kind of	Usual Occupation of work done during most of working DT use retired)	ng 16b	. Kind of Business	/Industry	
12	withii ene. <b>than</b>	g E	Elementary/Secondary (0-12) College (1-4or 5+)	·	_			
	e filed within al Hygiene. I other than "	S	11 0 Packer	& Inspector	(First, Middle, Maid	eryland (	Glass Cor	<u>-p</u>
Maryland	ould be Mental Larked o	o Be	Samuel Gwaltney	Gra				
7	2 should be and Mental is marked c	2		dress (Street and Number or Rura		-	7:- 0/-1	
Z	nd 2 salth an 27 is ir trau		lvener i					
စ်	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural", or itema 23a or 28a-f show any fijury or other traumatic avent, the Medical Examiner must be notified at 0008.		20a. Method of Disposition 120b. Place of Disposition	thorne Road, Li	athicum,	Varyland Location - City or	21090 Town State	
Baltimore,	permit. Pages 1 a Department of Hea Important: If itam any injury or othe once.		1  Burial 2  □ Cremation 3  □ Removal from State	or other place)	1			
Ē	permit. Pag Department mportant: I any injury o			Mem Park   12-14	.−04 G1e	en Burnie	, Maryla	ınd
Ba	permi Depa Impo any ir			11y-Polyniak Fu East Patapsco A	neral Hou	ne P.A.	21225	
			23a. art1. Enter the disease, or complications that caused the death. Do not enter the	East Patapsco A	venue, Bal	timore,	Maryland Approximate	L
	445000		hock, or heart failure. List only one cause on each line.	/	respiratory arrest,		Interval Betwee	en ath
	Physician /Medical		disease or condition (Oronary will	y disease				
	Examiner		Due to (or as a consequence of):	6 6-1m				
		Ē	Sequentially list conditions, if any, leading to immediate  b. Conference Ren  Due to ( Jas a consequence of):	of fair con				
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	. lum de	stur			
	al-tra	xai	Cause (Disease or injury that initiated events resulting in death) Last  C. Lhrue Obstnehm  Due to (or as a consequence of):	the first	rup			
8760,	icate be executed physician and s the burial-transit	dical						
89	ficate g phy is the	edic	0.					
Вох	that the death certifiled by the attending properties as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of de	liven.	
ğ	d for	ciai	in the past 12 months?	r (specify)		Month	Day Yea	ar
0	the c	Jysi	9 ☐ Unknown					
٦	The law requires that the death certifi ste has been signed by the attending I cage 2 should be detached for use as	by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying	ing cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of dea	ath?
rds	quire; n sig				1 ☐ Yes	200 No 3 □ Pr	obably 4 Uni	known
Records,	w rec	Completed			24a. Was an	24h Were a	utopsy findings ava	aulablo
Re	The lar	шć			autopsy performed	prior to	completion of caus	
Vital		C	25. Was case referred to medical		1 Yes 2 2	No 1 ☐ Yes	2/S-No	
5	Physician: this certific al director,	o B	examiner?	26. Place of Death	11			
of		H-	27. Manper of Duath 28a. Date of Injury (Month, Day Year)  28b. Time of Injury (Month, Day Year)	4 Nursing Hor	8d. Describe how in	6 □Other (Spe	cify)	
o	tanding Ph leath. tor: After th the funeral	tio	1 Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation M	Work? 1 ☐ Yes 2 ☐ No		,,		
Division	f or Attandi after death. Director: A in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not be	ctory, office 2	8f. Location (Street	and Number or Ru	ıral Route Numbe	r.
Ö	afor afte Dire	erti	4 Homicide building, etc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	City or Town, Sta	ate)		
	To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: Attercompletely filled in by the fune		29a. Certifier Certifying Physician: To the best of my knowledge, death occu	rred at the time, date and place, a	nd due to the cause	(s) and manner as	stated	
	na Ho 1 24 t na Fu detely	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	ition, in my opinion, death occurre	d at the time, date a	and place, and due	to the cause(s)	
	To the Withir To the Comp	M	29b. Signature and title of coefficier	29c. License number	29d. [	Date signed (Monti	h, Day, Year)	
			· Mys ms	1) 201,0V		2/10/01	1	
	0		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1/-,03/		1 / /	/	
	P		YEONG OH 1412 CRAIN H.W	N 64 6	5B M	N		
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature		-			
	Registr	ar	DEC 1 4 2004 Sender & Soa	Kr				

			1- For State Registrar	tate of Ma	aryland / Dep <i>Ce</i>	artment of I rtificate of	Health and N Death	Mental Hygie Reg.		39462	
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Death	Day Year	3. Time of Death	
	/Medic	cal	Frances H. Bolth				of Leasting of Death	DEC. 9	2004	7:10p M	
	Examir	ıer	College Manor Assi		ving		or Location of Death  1therville		4c. County of Death		
	Funeral		Social Security Number 6. Sex	7. Age	(In yrs. last birthday	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min,	8 Date of Birth	9 Righ	imore place (State or Foreign intry)	
	Director		228-09-9431 1 ☐ M Usual Residence of Decedent	X	84 Yrs.			NOV. 29,	1920 Mar	yland	
	yland how		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits	
	ne Ma Se-fs	Director	Maryland N/A			Balt	imore			1XiYes 2□No	
	with ti		10e. Street and Number 1220 W. Lake Ave	nue		10f. Zip Code 212	10	10g.	Citizen of What Cou	,	
	death	Funeral	11. Marital Status 12.	Was Decedent E	ver in U.S. 13.	Was Decedent of H	lispanic Origin? (Sp	ecify Yes or No-	14. Race - Ameri	USA ican Indian,	
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mentat Hygiene.  If item 27 is marked other than "netural", or Items 23a or 28e-1 show or other treumatic event, it a Marical Examinational teams if ited and or other treumatic event.	þ	- William I - I - I - I	Armed Forces? 1 □ Yes 2 2 No If Yes, Give Year or Dates:	0	1 ☐ Yes 2 ☒ No	an, Mexican, Puèrto Specify:	Rican, etc.)	Specify: LT	, etc. nite	
21215-0036	72 ho 'netur	Completed	15. Decedent's Education (Specify only highest grade co.	on mpleted)	16a. Dece	dent's Usual Occup	eation	16b	. Kind of Business/Ir		
121	within ane. than "	mp		College (1-4or 5-	F) _	DO NOT use retired Cretary	during most of work	1	Dalara a tabara		
2	filed Hygid other	Be Co	17. Father's Name (First, Middle, Last)		560	recary	18. Mother's Name	e (First, Middle, Maid	Education		
ylar	2 should be filed within and Menta! Hygiene. Is marked other than eumatic event, It's M.	To B	Edward I II 1 1							Ginty	
Maryland	12 sho		19a. Informant's Name/Relationship (Type,	•					ty or Town, State, Zip	Code)	
	Health tem 27 other tr		Elizabeth Bolth Sw 20a. Method of Disposition	ranson/d	20b. Place of Dispo	sition (Name of			nore, MD 2 Location - City or To	21210	
timore,	Pa Int		1 ☐ Burial 2 🔁 Cremation 3 ☐ Remo `4 ☐ Donation 5 ☐ Other (Specify)	val from State		matory or other place ematory,	$\stackrel{\scriptscriptstyle(e)}{\operatorname{Inc}}$ $\stackrel{\scriptscriptstyle(e)}{\stackrel{\scriptscriptstyle(e)}{\operatorname{Inc}}}$ $12/10$		Baltimor		
Balt	permit. Departm Importa eny inju		21. Signature of Funeral Setates Licenses  Dawn F McDona	mald	2	remation 99 Frede	ssociety crick Road	of Marylar Baltimor	nd, Inc. re, MD 212	228	
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one can	ons that caused tause on each line	the death. Do not en	er the mode of dyin	g, such as cardiac o	or respiratory arrest,	-c, 110 212	Approximate Interval Between	
	Pr <del>rysician</del> /Medical	ì	Immediate Cause (Final disease or condition resulting in death)	hujeco	ndul	infriction	ie .			Onset and Death	
B	Examiner		1	Due to or as a	consequence of):				: 9		
	70 4#	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Under vin	Due to (or as a	consequence of):						
	xecute and Il-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):						
68760	icate be executed physician and s the burial-transit	edical E	d	,							
_	artifica ing ph e as th		IF FEMALE:								
BOX	leath certi attending I for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?	f yes, outcome o 1□Live birth 2 4□Pregnant at ti	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive	ery Day Year	
J.	at the de by the	hysid	1 Yes 2 No 9 Unknown	Unknown	3	Other (specify)					
	igned to	by P	Part II. Other significant conditions contribu	iting to death but	not resulting in the u	nderlying cause give	en in Part I.	23e. Did tobacc	o use contribute to th	ie cause of death?	
ecords,	w requir been si should	eted						1 🗆 Yes	2 □ No 3 □ Prob	ably 4 Unknown	
r	sicien: The law requires that the death certificate be executed certificate has been signed by the attending physician and trector, page 2 should be detached for use as the burial-transit	Completed						24a. Was an autopsy performed	Prior to cor death?	psy findings available mpletion of cause of	
Vital	sicien: certifica rector, p	Bec	25. Was case referred to medical examiner?				26. Place of Death	(Check only one)	No 1 ☐ Yes	2□No Assisted	
0	hy his	J.	1 ☐ Yes 2 No Hospi  27. Magner of Death 28	tal: 1 ☐ Inpatient 3a. Date of Injury	t 2 ER/Outpatien	t 3□ DOA Othe	4   Nursing Hor	ne 5 Residence			
0	Attending I sr death. ector: After by the funer	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year) Injury	Worl	(? Yes 2 □No	8d. Describe how in	jury occurred		
UIVISION	or Attendate death Director: in by the	Certification;	3 Suicide 6 Could not be determined 28	Be. Place of Injury building, etc.	y - At home, farm, str. (Specify)	eet, factory, office	2	8f. Location (Street: City or Town, Sta	and Number or Rura	l Route Number,	
ב	pitel c		29a. Certifier 1X Certifying Physicia	<del>-</del>					ŕ		
	To the Hospitel or Attendwithin 24 hours after death To the Funerel Director: completely filled in by the	edical	(Check only 2 Medical Examiner:	On the basis of e and manner state	examination and/or inv	restigation, in my or	e, date and place, a pinion, death occurre	and due to the cause and at the time, date a	(s) and manner as st and place, and due to	ated. the cause(s)	
	To the within To the comple	Σ	29b. Signature and title of certifier	0		29c. License		29d. D	Date signed (Month, I	Day, Year)	
(	1		30. Name and address of person who comple	ulle	MUD 320) Time	D24	121	12	110/04		
	0		BRUCE ROSENE	//	ath (Item 23a) (Type, 21 WE	_	TOWSO.	U MD 21	204		
	Stat		31. Date filed (Month, Day, Year)	32. Registrar'		1		/	- 5 1		
	Registra	3f	DEC 1 4 2004	1 ance	pres fig	porks	1				

			1 - For State Registrar	State of Ma	arylan		artment rtificate				_	ene 0 0	-	39463							
	Diam'r.		1. Decedent's Name (First, Middle, Las	it)							. Date of Death	1 Day V-	ar.	3. Time of Death							
	Physici /Medio			glas	Bark	ter				]	Decembe	r 10, 20		6:30 A M							
	Examir	ner	4a. Facility Name (If not institution, give	street and number)			4b. City, To					4c. County of E									
	Funevel		13817 Bauer Dr. 5. Social Security Number 6. S	ex 7. Aa	e (In vrs.	last birthday)	If Under 1		kvil.		. Date of Birth	9		omery ace (State or Foreign							
	Funeral Director			<b>⊠</b> M 2□F	56	Yrs.	Months I	Days	Hours	Min.	(Month, Day,	1948	Count	ntucky							
	p ,		Usual Residence of Decedent		10- 0	. T															
	Manyia -f shov	tor	Maryland Montgo	mery	100.01	y, Town or Lo		ockv	ille				10	od. Inside City Limits 1 ☐ Yes → No							
	th the	Director	10e. Street and Number				10f. Zip C	ode			10	g. Citizen of Wha	Count	try?							
	23a		13817 Bauer Dr.					2	0853			United	St	ates							
36	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or Items 23a or 28e-f show avent, the Medical Eraciner mast be notified at	by Funeral	Marital Status     Never Married 2∑ Married     Widowed 4 □ Divorced	12. Was Decedent Armed Forces?  1 X Yes 2 1 If Yes, Give Year or Dates:	No	_   '	Was Deceder f Yes, specify 1 ☐ Yes 2		panic Original Property: Specify:	gin? (Speci n, Puerto Ric	fy Yes or No- can, etc.)	14. Race - A Black, V Specify:	/hite, e								
9	2 hou		15. Decedent's Ed	lucation	. 100	16a, Deced	dent's Usual (	Occupat	tion		1	6b. Kind of Busine									
215	within 72 ene. than "nat	plet	(Specify only highest gra	de completed)  College (1-4or 5	i+)	life. l	kind of work DO NOT use	retired)		t of working				,							
21	filed within Hygiene. Ither than ant, the Me	Completed		4	,		Self H					Archives	Re	search							
land	ld be fill ental Hi ked off	To Be	17. Father's Name (First, Middle, Last)  Bert C.	Barl	ker				_	er's Name <i>(f</i> O <b>ra</b>	First, Middle, M	Rader									
Maryland 21215-0036	s 1 and 2 should be f f Health and Mental b item 27 is marked of other traumatic ave	-	19a. Informant's Name/Relationship (7	**							Route Number,	City or Town, Stat	_	Code)							
	of Health item 27		20a. Method of Disposition	, wire	20b. P	lace of Dispo	sition (Name	of	1 -	Dat		Oc. Location - City		vn. State							
E O			1 ☐ Burial 2 🌠 Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify			emetery, cren sapeak				12/13,		Beltsv:									
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Servin Cicy	99	M003	22 R	Name and	Address	of Facility	nd Cre		Service:		910							
	Pnysician		23a. Part1. Enter the disease, or compshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused one cause on each lin	I the death		er the mode of							Approximate Interval Between Onset and Death I Months							
	/Medical Examiner			Due to (or as	a conseq	uence of):															
	cuted nd ransit	Ical Examiner	lcal Examiner	Ilcal Examiner	Ilcal Examiner	llcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Clauses of Listage of Ity) that initiated events	Due to (or as	Due to (or as a consequence of):												
8760,	the death certificate be executed y the attending physician and sched for use as the burial-transit						lical Ex	lical Ex	Ilcal Ex	lical Ex	lical Exa	Ical Exa	Ical Exa	Ical Exa	ilcal Exa	dical Ex	resulting in death) Last  Due to (or as a consequence of):  d.				
9	eath certific attending pl	/Med	IF FEMALE:	23c. If yes, outcome	of pregna	incv						22d Date of									
.O. Box	it the death by the atten tached for u	ed by Physician/Me	by	by	by	by	by	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	I death 3	Ectopic preg Other (spec					23d. Date of Month		y Day Year		
<u>a</u>	res that igned b							Part II. Other significant conditions of	ot resulting in the underlying cause given in Part I.				3e. Did tobacco use contribute to the cause of death?  1  Yes XXNo 3 Probably 4 Unknown								
Records,	The taw te has b age 2 sl	Completed									24a. Was an autopsy perform 1 Yes 2	ed? prior	to com ?	sy findings available pletion of cause of							
Vital	sician: 1 certifical rector, p	Be (	25. Was case referred to medical examiner?					-		of Death (C	Check only one	n.									
of \	Physician: this certific ral director,	ို	1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatie		ER/Outpatien	The State of the S	Other	4 🗆 1401			ce 6 Other (S	pecify)								
ion	ding h. After fune	ation:	27. Manner of Death  1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day	y Year)	28b. Time of Injury	M 28c	. Injury a Work? 1 \( \text{Ye}	at es 2.∐.N	0	d. Describe how	injury occurred									
Division	of or Attand after death Director: A	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	ury - At ho	ome, farm, stre	eet, factory, o	ffice		28f	Location (Stre City or Town,	et and Number or State)	Rural	Route Number,							
	To the Hospitel or Attan within 24 hours after deatl To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1  Certifying Ph. (Check only one)	ysician: To the best of niner: On the basis of and manner sta	examina	wledge, death tion and/or inv	occurred at restigation, in	the time	, date and nion, deat	d place, and h occurred	I due to the cau at the time, dat	ise(s) and manner e and place, and c	as sta lue to t	ted. he cause(s)							
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. L	icense	number		290	d. Date signed (Mo	nth, D	ay, Year)							
	. \		1 grash	- 8	20	2		D4	3083			Decembe	1	3, 2004							
(	311		30. Name and address of person who deeper A. Sotos				,	r Dr	. #3	00; R	ockvill	e, MD 2	0850	0							
	Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signa	ture	-	1:11:00	-												
	Registr	ar i	DEC 1 4 20	14 Ciene	wa	B	Million	1	1												

			For State Registrar	State of Maryland / Dep	ertificate of Death			4
			Decedent's Name (First, Middle, Last,		ranoate of Beath	Reg. I	No.  3. Time of De	ath
	Physici		Tridonna Loleita	a Burton		Month	Day 2, 102004 6.30A	₩ M
	/Medic Examin		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Do		4c. County of Death	
		Ŭ.	MORGET ARUN	DER HOSPITAL	Ed EN BUR	JIR I	ANNE ARUNDA	EL
	Funeral		Social Security Number     6. Security Number	7. Age (In yrs. last birthday		Irs. 8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Fo	
	Director		220-02-2700	M 2 XF 38 Yrs.	Months Days Hours N	04/20/196	6 Maryland	
	pu k		Usual Residence of Decedent  10a. State 10b. County	10c. City. Town or L	ocation		40d Inside City	
	sho	'n	,				10d. Inside City L 1 ☐ Yes 2X	
	the N	Director	Maryland Anne Arus  10e. Street and Number	ndel Pasaden	a 10f. Zip Code	110-		
	with						Citizen of What Country?	
	eath ns 23	Funeral	920 Druid Hill Ave		Was Decedent of Hispanic Origin?		U.S.A.  14. Race - American Indian,	
′0	r Iten	F	1 X Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 XNo	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	erto Rican, etc.)	Black, White, etc.	
8	al', o Exan	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 💢 No Specify:		Specify: Black	
21215-0036	filed within 72 hours atter death with the Maryland Hygiene. thar than "natural", or Items 23a or 28e-f show that, the Madkeal Examinar must be notified at	Completed	15. Decedent's Edu (Specify only highest grad	cation 16a. Dece	edent's Usual Occupation e kind of work done during most of	16b.	Kind of Business/Industry	
7	ithin Ban Mag	n du	Elementary/Secondary (0-12)		DO NOT use retired)	Jorang		
	ygier ygier tr. th	Cor		1 Cash	ier Clerk		etail	
<u>n</u>	tal H	Be	17. Father's Name (First, Middle, Last)			Name (First, Middle, Maid	,	
3	should be filed within nd Mental Hygiene. I marked other than umatic event, the M	은	Robert Daniel Burt			Louise Johns	······································	
Maryland	12 sho h and 7 Is m treum		19a. Informant's Name/Relationship (Ty	920	ing Address <i>(Street and Number or</i> D <b>ruid</b> Hill Av <b>e.,</b>			
	ss 1 and 2 of Health item 27 I		Robert D. Burton /	20b. Place of Disp	osition (Name of		Location - City or Town, State	
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than. Important: If item 27 is marked other than. Insuring or other treumatic event, the Medical Examiner must be notified at once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ P	Removal from State cemetery, cre	ematory or other place)		•	
₽	artme ortan injury		' 4 ☐ Donation 5 ☐ Other (Spacify)  21. Signature of Funeral Service Licen				ndsdowne, Marylan . Jones F/H, P.A.	
Ba	permi Depa Impo any i						ore, Maryland 212	
			23a. Part1. Enter the disease, or compli	ications that caused the death. Do not en			Approximate	
	N. Marie		Immediate Cause (Final				Interval Betwee Onset and Deal	
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence of):	1 X EAST C	AJUCEIR		
ľ	Examiner			MALICONARY	BREAST C	EFFUS	104	
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):			•	
	cuted	Examin	that initiated events					
, 0,	e exe		resulting in death) Last	Due to (or as a consequence of):				
8760,	cate be executed physician and the burial-transit	dlcal						
9	ertific ding p	0	IF FEMALE:	20 Huga automa of assessment				
Вох	that the death certifi ed by the attending I detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy	i	23d. Date of delivery  Month Day Year	r
o.	he de	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	Other (specify)			
<u>a</u>	The law requires that the death certif tie has been signed by the attending page 2 should be detached for use a		Part II. Other significant conditions cor	ntributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacci	o use contribute to the cause of death	h?
Vital Records,	puires n signal	d by				1 ☐ Yes	2 □ No 3 □ Probably 4 □ Onkr	nown
00	w requir been si should	Completed				24a. Was an	24b. Were autopsy findings avail	lable
Be	The lav	mc				- autopsy performed)	prior to completion of cause death?	
ta		0	25. Was case referred to medical		26 Place of F	1 ☐ Yes 2 ☑ ↑	No 1 ☐ Yes 2 ☑ No	
<u> </u>	Physicien: r this certificaral director, I	OB	examiner? 1 ☐ Yes 2 ☑ No	lospital:	Other	g Home 5 ☐ Residence	6 □Other (Specify)	
J Of		n; T	27. Many r of Death	28a. Date of Injury (Month, Day Year) 28b. Time of Injury		28d. Describe how in		
<u></u>	tendir Jeath. tor: Af the fur	atlc	1 Natural 5 Pending investigation	,,,	M 1 ☐ Yes 2 ☐ No			
Division	after deatl after deatl Diractor: In by the	Certification;	3 ☐ Suicide 6 ☐ Could not be d. ermined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)	
	To the Hospital or Attending within 24 hours after death. To the Funeral Diractor: After completely filled in by the fune							
	24 hours 24 hours 8 Funeral etely filled	edical	29a. Certifier (Check only one)  1 ✓ Certifying Physical Examination 2 ☐ Medical Examination	sician: To the best of my knowledge, dea ner: On the basis of examination and/or in	th occurred at the time, date and pla evestigation, in my opinion, death oc	ice, and due to the cause corred at the time, date a	(s) and manner as stated. Indiplace, and due to the cause(s)	
	To the within 2. To the Complete	Mec	29b. Signatura - Jule of certifie	and manner stated.	29c. License number	29d [	Date signed (Month, Day, Year)	
	F 3 F 8		) Harris	lace Mi				204
1	h		30. Name and address of porson who on	ompleted cause of death (Item 23a) (Type	Print	0		- 1
	')		WARAIT	12 4 1	al Drive 9	Gen Buss	ne MD 21061	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	4 /		CEMBER 10 20061	
	Registr	ar	DEC 1 4 2	004 Denevar	poorles			

39465 State of Maryland / Department of Health and Mental Hygiene [] [] [] For State Registrar Certificate of Death 2. Date of Death 3. Time of Death' 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 6:00p M December 12, 2004 Mary Elizabeth Bowery /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Charlestown Care Center Catonsville Baltimore 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 X F 13,1919 220-05-1024 85 Feb. Maryland Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Catonsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 715 Maiden Choice Lane HV304 21228 U.S.A. r deeth v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or impay or other trainment. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Colfege (1-4or 5+) 12 Law Firm Stenographer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas C. Siffrin Myrtle M. Greenwood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Siffrin (Nephew) 2613 Mountain Road Pasadena, Maryland 21122 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial 12-15-2004 Elkridge, Maryland 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Witzke Funeral Home of Catonsville, Inc. M00869 1630 Edmondson Ave. Catonsville, Maryland 21228 23a. Hart1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, book, or heart ailure. List only one cause on each line. Approximate Interval Between Onset and Death fmmedial Cause (Pinal disease or condition resulting in death) ementes Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Jause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ ero Claroly Carolovaruler 2/ No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performed? Yes 20 No 1 ☐ Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospitaf: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 1 Yes 2 No Certification: To Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death Director: the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier DO20090 29d. Date signed (Month, Di Chorie Case, Callowally (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) varu Maiden 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar

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Vital Records, P.O. Box 68760,	ttending Physician: The law requires that the de
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			For State of I	Maryland / Depa <i>Cei</i>	artment of Health an rtificate of Death	d Mental Hy	giene 0 4	39466
			1. Decedent's Name (First, Middle, Last)			2. Date of De	path Day Yea	3. Time of Death
	Physicia /Medic		Patricia Ann	Baff	ord	Decemb		12:05 A <sup>M</sup>
	Examin		4a. Fecility Name (If not institution, give street and number	er)	4b. City, Town, or Location of D	eath	4c. County of De	ath
			Gilchrist Center	A - // /- /- /- /- /- /- /- /- /- /- /	Towson If Under 1 Year   If Under 24	Hrs   0 D ( D:	Balti	
	Funeral Director		247-35-0934 1□M 2\\ F	Age (In yrs. last birthday) 43  Yrs.		Min. (Month, Da	9. 8 9. 1961 0	irthplace (State or Foreign Country) aklahoma
and	* 1		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
o after death with the Maryland	f sho	ō	Manual and Baltimans	Dhao				1 ☐ Yes 2 No
the	28a rodul	Director	Maryland Baltimore  10e. Street and Number	Phoe	10f. Zip Code		10g. Citizen of What (	Country?
with	3a or	0	13805 Princess Anne Way		21131		USA	
death	ms 2	Funeral	11. Marital Status 12. Was Decede Armed Force	ont Ever in U.S. 13.	Was Decedent of Hispanic Origin's If Yes, specify Cuban, Mexican, Po	? (Specify Yes or No		nerican Indian,
UUSO hours after	f Health and Mental Hygiene. item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, I've Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☒ Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Date	<b>∑</b> No	1 ☐ Yes 2 ☑ No Specify:	uerto nicari, etc.)	Specify:	hite
<b>3-003</b>	ature cal E	ted	15. Decedent's Education	16a. Dece	dent's Usual Occupation		16b. Kind of Busines	
hin 7	en "n Med	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4)	or 5+)	kind of work done during most of DO NOT use retired)	working		
C Z IZ I	gien er th	CO	12 02		inistrator		Insur	ance
	d oth	Be	17. Father's Name (First, Middle, Last)		18. Mother's	Name (First, Middle	, Maiden Sumame)	
aryland	Men arke	ို	Charles Nico			Betty	Har	
Mar 2 sh	7 Is m		19a. Informant's Name/Relationship (Type, Print)	1	ng Address (Street and Number of			
1 and	Health as 27 ls		William C. Bafford/Husbar 20a. Method of Disposition		05 Princess Ann	e Way, Ph	oenix, MD  20c. Location - City of	21131 or Town State
10r	in its		1   Burial 2 □ Cremation 3 □ Removal from Sta	118	esition (Name of matory or other place)			
Saltimor sermit. Pages	ortant ortant njury	1	21. Sign Ture of Eune al Service Centre		ge Cemetery   1.  2. Name and Address of Facility	2/11/04	Pikesvill	e, Maryland
De d	Department of Healt Important: If item 2 eny injury or other once.		Lowell M. Lemmon	mar	Lemmon Funeral   10 W. Padonia R	Home of Doad, Timo	ulaney Val nium, MD	ley Inc. 21093
			28a. Part 1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each	sed the death. Do not ent h line.	er the mode of dying, such as can	díac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	ysician :		Immediate Cause (Final disease or condition	taspani	Meast Canc	n		4cos
	Medical xaminer		resulting in death)  Due to (or	as a consequence of):				1.
		ē	Sequentially list conditions, if any, reading to immediate	as a consequence of).				
1/1	Insit	를	cause. Enter Underlying Cause (Disease or injury that initiated events	, ,				
execi	in and	Examin		as a consequence of):				
oa/ou, ificate be ex	physician and the burial-transit	edicai	d					
	0, 40		IF FEMALE:				i	
Geath cert	attending for use as	ician/M	23b. Was decedent pregnant  1 Live birth	n 2 ☐ Fetal death 3 ☐	Ectopic pregnancy		23d. Date of d Month	elivery Day Year
5 % S	the a	hysic	1 ☐ Yes 2 MaNo 4 ☐ Pregnan 9 ☐ Unknown 9 ☐ Unknown		Other (specify)			
F tal	ad by detac	۵.	Part II. Other significant conditions contributing to deat	h but not resulting in the u	nderlying cause given in Part I.	23e. Did t	obacco use contribute	to the cause of death?
ecords, P.O.	been signed by the attendin should be detached for use	d by				10	Yes 2□No 3	Probably 4 Unknown
ecol	shou	ompleted				24a. Was	an 24b. Were	autopsy findings available
	<u>c</u> <u>o</u>	mo				— auto perfo 1 ☐ Yes	prior to printed? death' 2 No 1 7 Year	autopsy findings available ocompletion of cause of ?
	certificate rector, pag	0	25. Was case referred to medical		26. Place of	Death (Check only		33 2010
		To B	examiner? 1   Yes 2   No   Hospital: 1   Inp	atient 2 EP/Outpatier	nt 3 DOA Other: 4 Nursin	ng Home 5 ☐ Resi	dence 6 Other (Sp	pecify) DSCCO
n Of ng Phy	fter th		27. Manner of Death 1 Natural 5 □ Pending  28a. Date of 1 (Month,	njury 28b. Time of Injury	f 28c. Injury at Work?	28d. Describe	how injury occurred	
S S	or: A the fu	cati	2 Accident Investigation		M 1 Yes 2 No			
DIVISION OF VITA	Direct in by	Certification:	determined 286. Place of	Injury - At home, farm, str , etc. (Specify)	reet, factory, office	28f. Location ( City or To	Street and Number or . wn, State)	Rural Route Number,
Spital	ours a	al Ce	29a. Certifying Physician: To the be	est of my knowledge, deatl	h occurred at the time, date and p	lace, and due to the	cause(s) and manner	as stated.
the Hos	within 24 hours after death.  To the Funerel Director: After this completely filled in by the funeral di	Aedical	(Check only 2 Medicel Examiner: On the basi and manner	s of examination and/or in	vestigation, in my opinion, death of	occurred at the time,	date and place, and di	ue to the cause(s)
Tol	To	Σ	29b. Signature and little of certifier	$\circ$	29c. License number		29d. Date signed (Mo.	nin, Day, Year)
			30. Name and address of person who completed cause	of death (Item 22a) (Tuna	Print) O 4		, , , , ,	, ,
	le		BALON J. CHARLES, V	M 6601	29c. License number VS7303 Print) Charles S	or Balti	were lup ?	21204
	Sta Registr		31. Date filed (Month, Day, Year) 32. Reg	istrar's Signature	pouls			

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State Registrar 31. Date filed (Month, Day, Year)

4 2004

Box 68760

P.O.

Division of Vital

		4	For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of H	lealth and l Death		ier <b>2e</b> 0 0 4	39468
			Decedent's Name (First, Middle, La	st)				2. Date of Death	h	3. Time of Death
*	Physici / /Medic		MARY	Ε.	BURTO	V		Month 12-12-2	Day Ye 2004	12:45 A M
and .	Examin		1a. Facility Name (If not institution, given	e street and number)			r Location of Deat	1	4c. County of E	Death
3	4.	8.	HERITAGE CENTER		- Alexander de la lace de lace de lace de lac	DUNDAL If Under 1 Year		O Data of Birth		IMORE Birthplace (State or Foreign
點	Funeral Director		5. Social Security Number 6. S 215–22–1628	ion 2. XF /. Ag	e (In yrs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 04-16-19		Country) VA
			Usual Residence of Decedent		09			04-16-19	713	VA
	how		10a. State 10b. County	ND F	10c. City, Town or Lo	cation				10d. Inside City Limits
	8e-f s	cto	MD BALTIMO	JKE 	EDGEMERE					1 X Yes 2 □ No
	with the	Dire	10e. Street and Number	DOAD		10f. Zip Code	010	10	0g. Citizen of Wha	t Country?
	leath	Funerai Director	2438 LODGE FARM	12. Was Decedent	Ever in U.S. 13.	Was Decedent of H	219 lispanic Origin? (S	pecify Yes or No-		American Indian,
36	thin 72 hours after death with the Maryland e. e. Marical Exactive or 18e-6 show Marical Exactive or 18the natified at	by Fun	1 Never Married 2 Married 3   Widowed 4 Divorced	Armed Forces?  1 ☐ Yes 2 ☑  If Yes, Give  Year or Dates:	No.	If Yes, specify Cuba 1 ☐ Yes 2 ☐ 📉 o	an, Mexican, Puerl Specify:	o Rican, etc.)	Specify: B	Vhite, etc.  LACK
21215-0036	72 hou nature		15. Decedent's E		16a. Dece	dent's Usual Occup	pation	rking	16b. Kind of Busine	ess/Industry
215	within 7 ene. then "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5	life.	DO NOT use retired	d)	ning .		
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and	e d a b y	Be	17. Father's Name (First, Middle, Las. CHARLIE SMITH	7				LONG	vaiden Sumame)	
Maryland	s 1 and 2 should b f Health and Ment item 27 ie marked other treumetic e	2	19a. Informant's Name/Relationship	(Tvpa, Print)	19b. Maili	na Address (Street		ral Route Number,	City or Town, Sta	te, Zip Code)
Ma	nd 2 sho Ith and 27 ie m		MR. MILTON WELLS			_		., EDGEME		
re,	s 1 and 2 if Health item 27		20a. Method of Disposition		20b. Place of Dispo	sition (Name of matory or other place	ce)	Date 2	20c. Location - City	y or Town, State
Ē	Pages ment of ant: If it ury or o		1 Burial 2 □ Cremation 3 [  1 □ Cremation 5 □ Other (Special Control of Cont		ARBUT	rus	12/	16/04 B	BALTIMORE	, MD
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Lice	Was to		2. Name and Addre	JA			ONS F.H., INC
		751	23a. Part1. Enter the disease, or conshock, or heart failure. List only	nplications that caused	the death. Do not en	ter the mode of dying	ng, such as cardia	or respiratory arre	est,	Approximate Interval Between
~	Physician		Immediate Cause (Final disease or condition	PN	EUM	11116	4			Curet and bland ?
Sec. T	/Medical		resulting in death)	Due to (or as	a consequence of):	0-0	):	1551	25	CUEAR
	Examiner		Sequentially list conditions, if any, leading to immediate	COKON	a consequence of):	MICK	7 1	SC 2 F6+	2F	6 FAT
	ed sit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	FSSE	ACT/(A)	HY	OFR	TEAC	SION	INVEARS
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9	ntificate ng phys as the	0	IE FEMALE.							
Вох	The law requires that the death certificate has been signed by the attending to age 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy	y		23d. Date of Month	f delivery Day Year
.o.	at the dea by the at tached fo	sici	1 Yes 2 No	4□Pregnant a 9□Unknown	time of death 5[	Other (specify)				
<u>α</u>	that the		Part II. Other significant conditions	contributing to death b	ut not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did tob	pacco use contribu	te to the cause of death?
Records,	uires signe ld be	d by	CHRONI	C RE	NAL	-A(L)	JRE	1 □ Ye	s 2000 3	Probably 4 Unknown
COL	w require been si should b	Completed		·				24a. Was ar	n 24b. Wen	e autopsy findings available
Re	The lav	omp						autops perform 1 Yes 2	ned2 deat	
Vital		o o	25. Was case referred to medical				26. Place of De	ath (Check only on		
of V	Q	To B	examiner? 1 □ Yes 2 No	Hospital: 1 Inpatio	ent 2 ER/Outpatie		4 Wursing i	fome 5 ☐ Reside	ence 6 Other (	Specify)
			27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28b. Time o	Wo		28d. Describe ho	ow injury occurred	
Sio	tend leath tor: the	icati	2 Accident investigation 3 Suicide 6 Could not	be 290 Place of In	ury - At home, farm, st		]Yes 2 □No	28f Location /Str	reet and Number o	or Rural Route Number,
Division	in City	Certification:	4 Homicide determine		c. (Specify)	ieer, lactory, office		City or Town		7187471188187748718871
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	the Holin 24 the Fu	Medical	one)	and manner st	of examination and/or in ated.					
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State of Maryland / Department of Health and Mental Hygiene | 14 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** John W. Bannon Month 4:02 2004 December /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Johns Hopkins Bayview Medical Center Baltimore NIA 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex Funeral Birthplace (State or Foreign Country) 1√2 M 2□F 18 Director 216-27-8079 June 28,1986 MD. Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 28a-f show 10d. Inside City Limits the Medical Examinat must be notified at Director 1 ☐ Yes 2 X No MD. Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Itams 23e or 2828 Plainfield Road 21222 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1X Never Married 2 Married 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ģ If Yes, Give Year or Dates: 3 Widowed 4 Divorced Specify: White naturel Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11 years Machine Operator International Paper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental F Pages 1 and 2 should bent of Health and Men Richard Edward Bannon Kelly Ann Simpson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 2828 Plainfield Road, Dundalk, MD. 21222 Kelly Ann Bannon mother other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State December 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ö permit. Page Department of Important: If any injury or once. Dulaney Valley Memor. 16,2004 Timonium, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 23a. Parti. Enter the disease, or complications that caused the death. Do no enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Status Asthmaticus Immediate Cause (Final disease or condition resulting in death) Anset and Death Physician 560515 /Medical Due to (or as a consequence of) Asthma 15 years **Examiner** KOSPINATO Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner a consequence of): The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Month Day Year of Vital Records, P.O. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à page 2 should be Pneumonia Completed 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? 2 No 1 Yes 2 No Hospital or Attending Physicien: funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division After 1 Natural 5 Pending investigation Injury safter death. death. 1 ☐ Yes 2 ☐ No 2 Accident in by the 3 🗌 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD Res-000 December 11, 2004 w Name and address of person who colleted cause of death (Item 23a) (Type, Print) 4940 Eastern Arenue Baynew Medical Center Baltimore, MD 21224 Johns Hopkins 32. Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 1 4 2004 Registrar

UNK 04-399
04-07928

RJ

Amend item#28e,perME,G838,12/15/04 TT
Amend item#28e,perME,G838,12/15/04 TT
Amend item#7,perFh,G838,12/14/04 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician LAWRENCE JOSEPH BUTTION Day Year /Medical December 9 2004 01:48 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 1008 Chesaco Avenue Baltimore County Rosedale 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Sex XXM 2□F **Funeral** 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 220-20-6083 Director 88 Yrs. 6-30-1927 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show of Health and Mental Hygiene. Itam 27 Is marked other than "natural", or Itams 23a or 28a-f shov othar traumatic evant, the Medical Examinar must be notified at 10d. Inside City Limits MD BALTIMORE Director ROSEDALE 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1008 CHESACO AVENUE 21237 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ՃYes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 No 3 Widowed 4 □ Divorced Specify: Specify: WHITE WWII ed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Complete 16b. Kind of Business/Industry 12 should be filed within in and Mental Hygiene.
7 Is marked other than "I Elementary/Secondary (0-12) College (1-4or 5+) MASTER MECHANIC C.J. LANGENFELDER 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) AUGUST BUTTION 2 JOSEPHINE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DANA MORAN/ DAUGHTER 9530 GOOD SPRING DRIVE PERRY HALL, MD 21128 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Jo 20c. Location - City or Town, State permit, Pages Department of Important: If it any injury or o 1X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) CARDENS OF FAITH CEM. 12-11-2004 BALTIMORE, MD 21. Signat re of Funeral Service Licenses 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE ROSEDALE, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Carbon Immediate Cause (Final Onset and Death **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of). or Attanding Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 □Ectopic pregnancy 4□Pregnant at time of death Month Year Day 5 Other (specify) should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? certificate 1 Yes 2 No 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 XYes 2 □ No Other: 4 Nursing Home 5 Residence 6 X Other (Specify) At Scene 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred subject in when 5 Pending investigation 1 Natural vehicular exhaust fumes death. 1 ☐ Yes 2 No the t 1:28 A M 2 Accident round 12/9/04 within 24 hours after deat To the Funaral Diractor: 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1008 CNECCO AVE. Baltimore County, MD seene at home in garage -lospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier To tha 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME December 9, 2004

State Registrar

24

Prince E. Southall, MD
31. Date filed (Month, Day, Year)
DEC 1 4 2004
32. Registr

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

racks

111 Penn Street, Baltimore, Maryland 21201

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Lee	aibl
ricase rype or rime in Black machbie inte	mileare vill achiec vile me	3

State of Maryland / Department of Health and Mental Hygiene [] [] [ 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 0855Am Month Day Year Physician December 8 MELVIN CHARLES BENHOFF 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Easton Hospital at Easian Tailoot Memorial If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral X**XM 2□ F 73 Director Jan, 18, 1931 Balto.MD 215-28-6187 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County itam 27 ia marked other than "natural", or Items 23a or 28e-f show other traumatic avant, the Medical Examinan must be notified at 1 ☐ Yes 2 ☐ No Director Queen Anne's Grasonville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1033 Longpoint Road 21638 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status ∏Yes 2 No Yes, Give 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 X No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1952<u>-54</u> 2 should be filed within 72 hours and Mental Hygiene. is marked other than "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Paving Paving Contractor 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) J. Henry Benhoff, Jr. Ella Mae Kirkwood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or other trai Patricia Benhoff - wife 1033 Longpoint Rd. Grasonville, MD 21638 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem.Grds.12/13/04 Timonium, MD 21093 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 21. Signature of Funeral Service Licensee ohn O. Mil 23a, Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Reval Priysician moulti /Medical Due to (or as a consequence of): **Examiner** Dely div Sequentially list conditions, I any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of) ai the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 0 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death Diractor: 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. within 2 To tha To tha 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier SIDY D0046020 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 506 Idlewild Ave. Easton, MD 21601 Dr. Syed Ali

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

DEC 1 4 2004

Division of Vital Records, P.O. Box 68760,

32. Regiştrar's Signature

Mayara

			1 - For State Registrer	State of Man	yland / D	epartment of Headerst	alth and M eath		giene 0 0	39472
			Decedent's Name (First, Middle, La	ist)				2. Date of De.		3. Time of Death
	Physici /Medic		Lucy Dunbar Bi	sselle				Decem	ber 9, 200	54 11:50 AM
	Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or Lo	cation of Death		4c. County of D	eath
			5418 Kirkwood Dr				hesda f Under 24 Hrs.			gomery
	Funeral			Sex 7. Age (1 1 ☐ M 2 [X] F	In yrs. last birtl 92 Y		Hours Min.	8. Date of Birt (Month, Da	th y, Year) 9.	Birthplace (State or Foreign Country)
	Director		577-05-7412 Usual Residence of Decedent		92			June 2.	1, 1912 Wa	shington, DC
	yland		10a. State 10b. County	1	Oc. City, Town	or Location				10d. Inside City Limits
	a-f si	ctor	Maryland Montgom	ery	Bethes	da				1 ☐ Yes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	ath w	ra	5418 Kirkwood Dr			20816			United St	
	er de Items	Funerai	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	<ol> <li>Was Decedent of Hispa If Yes, specify Cuban, I</li> </ol>	anic Origin? (Spi Mexican, Puerto	ecify Yes or No Rican, etc.)	Black, W	merican Indian, /hite, etc.
36	irs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates:		1 ☐ Yes 2 No 3	Specify:		Specify: 1	Vhite
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	ed wil	Con		4	Of	fice Manager			Accountir	ng Office
nd	tal Hid oth	Be	17. Father's Name (First, Middle, Last	)					Maiden Surname)	
∑ Za	ould Men narke	2	Paul B. Dunbar		405		Alice L			- 7- 0- t-1
Maryland	d 2 sh th and 7 is n treun		19a. Informant's Name/Relationship (			Mailing Address (Street and				22102
	1 and Healt em 2		Charles A. Bisse		20b. Place of	6 Georgetown Disposition (Name of		Date	20c. Location - City	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23e or 28a-f show eny injury or other treumetic event, the Madical Exeminer must be nutified at once.		1 Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Special			crematory or other place)		ber 13	Unchinata	n D C
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ñ	Departiment Depart		+ A buile	Lenes. MO	0803	Bethesda-Che	evy Chas arvland	e, Inc.	7557 Wi 3501	sconsin Avenue
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	e dea he ati	Physician/M	in the past 12 months? 1 □ Yes 2 Å No 9 □ Unknown	4☐Pregnant at tim 9☐Unknown	ne of death	5 Other (specify)			Month	Day Year
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	To the Hospital or Attending Physicien: The law requires that the death certification 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical			camination and	death occurred at the time, for investigation, in my opini				
	o the o the omple	Mec	29b. Signature and title of certifier	and mariner states	<u>.</u>	29c. License no	umber		29d. Date signed (Mo	onth, Say, Year)
	F \$ F ō		1 Thomas	Hand	O Con	610	04		12/101	Toy
	. 7		30. Name and address of person who	completed cause of deal	th (Item 23a) (T		/			
	10		Thomas C. Havell	L, M.D. 420	1 Cathe	edral Avenue,	N.W., 1	Vashing	ton, D.C.	20016
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	& Sporks	1			
	Registr	ar	DEC 1 4 7	2004		~ jajunes	p*			

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Ì	Examin		4a. Facility Name (If not institution,	give street and num	nber)		4b. City,	Town, or	Location of	of Death			County of De	ath	
			Shady Grove Ad	ventist H	ospital			kvil				Me	ontgome	ry	
	Funeral			6. Sex 1. ★M 2. F	7. Age (In yrs. last		If Under Months	1 Year Days	If Under:	Min.	8. Date of Bir (Month, Da	iy, Year)		rthplace (State country)	or Foreign
	Director		220-42-3650	TAIN ZEIT	57	Yrs.					June 13	3, 19	947   Ma	ryland	
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Lo	cation							10d. Inside (	City Limits
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	os 1 and 3 of Health item 27 other tr		Walter C. Brewe	r, 111/50	20h. Place	of Dispo	sition (Nan	ne of			Choice		ennsy 1v ocation - City o		15550
Baltimore,	Pages nent of h int: If ite		1 ₺ Burial 2 ☐ Cremation		State Park	tery, crer	Memor Memor	ther place	9) D	eceml	per 14				
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г			23a. Part1. Enter the disease, or a shock, or heart failure. List of	complications that ca only one cause on ea	used the death. Dach line.	o not ent	er the mod	e of dying	g, such as	cardiac or	respiratory a	rrest,		Approxima Interval Be	etween
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			25. Was case referred to medical						26 Place	of Death	1 Yes		1 LI Y0	s 2 No	
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	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral	edical (		g Physician: To the Examiner: On the ba and mann	sis of examination										(s)
	To th withir To th compi	Me	29b. Signature and title of certifier				290	. License				29d. Da	te signed (Mon	th, Day, Year)	
			\( \lambda_{\tau} \)	~	_			DIS	236	G.		Dece	ember l	3, 2004	ŀ
	1,		30. Name and address of person v	who completed cause	e of death (Item 23	a) (Type,	Print)							_,	
	J		Carl I. Margo	olis, M.D.	1112	5 Ro	ckvil	le P	ike,	#211	Rocky	7 <b>i</b> 110	e, MD	20852-3	142
	Sta	ite	31. Date filed (Month, Day, Year)	32. Re	gistrar's Signature				·						
	Regist	rar	DEC 14	2004	Education .	19	Sp	ack-2	/						

Elliot Scott Belkov 04-07794 MAN

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

Amend item#6, 16a, per FH, G838, 12714/04 TI

State of Maryland / Department of Health and Mental Hygier@ | | | | |

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		1	For State Registrar			, , , , , , , , , , , , , , , , , , , ,	Ce	rtificate of	Death	R	leg. No.	0 0 %	0 14 14	
			1. Decedent's Name	(First, Middle, Las	st)					2. Date of Dea		Year	3. Time of Death	
	Physicia /Medic		ELLIOT			SCOTT_		BELK	(0)	Decembe		,200 <sup>4</sup> 4	1556 P M	1
	Examin		4a. Facility Name (If r	-		er)			or Location of Death	1		County of Death		
			2949 Fore					Croftor		Day of Diet		ne Arun		_
	Funeral Director		5. Social Security Nur 215-50-76	19 1	ex M 2 <del>∏</del> F	Age (In yrs. I	ast birthday, Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth 06/26/1	951	9. Birth	place (State or Foreign D.C.	п
	and	}	Usual Residence of D	10b. County		10c. City	, Town or L	ocation				1	0d. Inside City Limits	S
	e Maryl 8a-f sho	ctor		MONTGOME	RY	SI	LVER	SPRING			10. 001	(1)	1 ☐ Yes 2 💢 No	)
	3a or 24	by Funeral Director	10e. Street and Number 14510 HOM		RIVE			10f. Zip Code 2090	16			en of What Cour	ntry?	
	deati	ner	11. Marital Status		12. Was Decede	nt Ever in U.	S. 13.	Was Decedent of H	Hispanic Origin? (S	pecify Yes or No- o Rican, etc.)	. 14	4. Race - Americ Black, White,		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic evant. If Medical Evantre, must be ricillised at once.	l by Fu	1 Never Marrie 3 Widowed 4		1 XYes 2	NO MAKIN		1 □ Yes 2 🛣 No				Specify: WHI	TE	
2-0	72 hc 'natu	Completed		15. Decedent's Ed y only highest gra			/Give	dent's Usual Occup kind of work done	during most of wor	rking	16b. Kind	d of Business/In	dustry	
2	within ne.	ld m	Elementary/Secon	dary (0-12)	College (1-4	or 5+)	SAL	ESMAN retire	d)		DI	T A T 1		
7	ifed v Hygie thar t		17. Father's Name (F	First Middle Last	)		JALL	MAIN -	18. Mother's Nar	ne (First, Middle,		ETAIL Sumame)		_
and	d be f antal h ced ol	o Be	LOUIS		,		R	ELKOV	SYLVIA			(	CHARAK	
7	should be nd Mental marked c	스	19a. Informant's Nar	ne/Relationship (	Type, Print)			ing Address (Street		ıral Route Numbe	r, City or			
S	and 2 : ealth ar n 27 Is ner trau		MEREDITH	BELKOV /	SISTER		4819	SOUTH 30	th STREE	T, ARLIN	GTON:	, VA. 22	2206	
Baltimore,	s 1 a of Hea item othe		20a. Method of Dispo		35 14 0	20b. P	lace of Disp emetery, cre	osition (Name of ematory or other pla	CHELTENH	IAM <sup>®</sup>	20c. Loc	ation - City or To	own, State	
E	Pages nent of h ant: If ite ury or of		1 🖟 Burial 2 ∟ 1 4 🗆 Donation		]Removal from Sta fy)		VETER	ANS CEME	TERY 12/1	.0/2004	UPPE	R MARLB	ORO, MD	
alti	permit. Departri Importa any inju		21. Signature of Fun	eral Service Lice	nsee			2. Name and Addre						
<u> </u>	89 5 5 8		Tol	20/	- hom	$\rightarrow$		900 REIST				VILLE, N		
			23a. Part1. Enter the shock, or heart	e disease, or com t failure. List only	plications that cau one cause on eac	sed the death h line.	n. Do not er	iter the mode of dyi	ng, such as cardia	c or respiratory ar	rest,		Approximate Interval Between Onset and Death	
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	/Medical Examiner		resulting in death)	(	Due to (or	as a conseq			111	17	1/1.1	il.		
В	LAUTHIO		Sequentially list con	ditions,	b. Die to (or	as a consequence		MONIA,	Highluff	for ord half	त्राधाः	01.95		
	red	nin	Sequentially list con if any, leading to immodule cause. Enter Under Cause (Disease or in	lying njury	240 10 (0.			×.	11.00					
	and and al-train	Examiner	that initiated events resulting in death) Li		Due to (or	as a conseq	uence of):							
09289	e be c				d									
	certificate be executed nding physician and use as the burial-transi	Medicai												_
O. Box	ath atter for u	Physician/N	IF FEMALE: 23b. Was decedent in the past 12 r 1  Yes 2  Unknown	months?		h 2∏Feta nt at time of d	death 3	□Ectopic pregnand □ Other (specify) _	<b>су</b>		23	3d. Date of deliv Month	ery Day Year	
P.0	res that the de igned by the be detached to		Part II. Other signifi	cant conditions	contributing to dea	th but not res	ulting in the	underlying cause gi	ven in Part I.	23e. Did to	obacco us	se contribute to t	he cause of death?	
ds,	uires sign	d by								1 🗆 ነ	∕es 2□	No 3∏Prol	pably 4 Unknow	n
of Vital Record	aw requir s been si 2 should	ompleted								24a. Was		24b. Were auto	ppsy findings available	le
R	The lav	E								perfo	rmed? 2 ☐ No	death?	2 □ No	
ita	ian: The	Be C	25. Was case referr examiner?	ed to medical						ath (Check only o	ne)			
<u>f</u>	Physician: this certific ral director,	은	1 Yes 2 □ 1		Hospital: 1 In		ER/Outpati	ent 3 DOA		lome 5 Resid		Other (Speci	MAt scene	į.
	ding Ph h. After th funeral	0	27. Manner of Death	5 Pending		Day Year)	28b. Time	Wo		28d. Describe h	now injury	occurred	100 11 -0	d
Division	or Attending after death. Diractor: After in by the fune	Certification:	2√ Accident 3 ☐ Suicide	investigation 6 Could not I	5007101	lajuny - At h	7 2. 2		]Yes 2.⊡″No	28f Location (5	Street and	Number or Bur	Route Number,	4
Σ	after d Dirac	rtif	4 Homicide	determined	building	, etc. (Specif	() () ()	treet, factory, office	North .	City or Tov	vn, Star )	21 - 21	3	
	pital ours a aral l	_	29a. Certifier	1□ Certifying P		est of my kno		ath occurred at the t	time, date and plac	e, and due to the	cause(s) a	and manner as	stated.	_
	24 hos E Fun	Medical	(Check only one)	20XMedical Exa	miner: On the bas and manne	is of examina	ition and/or	nvestigation, in my	opinion, death occ	urred at the time,	date and	place, and due t	o the cause(s)	
	To the Hospital or Attenc within 24 hours after dealt To the Euneral Director: completely filled in by the	Me	29b. Signatur and	tille of certifier	Company of the Compan	^		29c. Licen	se number		29d. Date	signed (Month,	Day, Year)	
	\		1901	N.th	win)	M		0.C.				nber 04,	2004	
-	3		30. Name and addre	ess of person who	completed cause	of death (Iter	n 23a) (Type 111	Penn Str	eet, Bal				.201	
		ate	31. Date filed (Mont	FC 1 4 2		gistrar's Signa		Soon						
	Regist	raŗ	D	LOT - C	JUT /			1						

			1 - For State of Maryland / De Registrar	partment of Fertificate of			iene 004	39475
	Physici		Decedent's Name (First, Middle, Last)     WILLIAM BOWEN			2. Date of Dea Month DEC . 1	, 2004 Year	3. Time of Death 5:01 p M
	/Medic Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, o	r Location of D		4c. County of Death	
			MERCY MEDICAL CENTER	BALT	IMORE		N/A	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 218-58-9303 1 1 2 F 51 Yrs.	y) If Under 1 Year Months Days		Hrs. 8. Date of Birth Vin. APR 13		place (State or Foreign ptry) YLAND
	and *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location				Od. Inside City Limits
	Manyl f sho	ō	MD. N/A BALTI				[	1X Yes 2 □ No
	28e	Director	10e. Street and Number	10f. Zip Code		1	0g. Citizen of What Cour	
	3a o	D	253 S. REGESTER STREET	2	1231		U.S.A	•
	death	Funeral				? (Specify Yes or No- uerto Rican, etc.)	14. Race - Americ	an Indian,
9	after or ite	/Fu	1 XNever Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 No	Specify:	uerto Hican, etc.)	Black, White,	
8	hours urel',	d by	3 Wildowed 4 Divorced Year or Dates:				Specify: WHI	TE
7	n 72 "net	lete	(Specify only highest grade completed) (Gi	cedent's Usual Occup ve kind of work done o . DO NOT use retired	during most of	working	16b, Kind of Business/Inc	dustry
21215-0036	with iene.	Completed	Elementary/Secondary (0-12)   College (1-4or 5+)	TEVEDORE	•/		SHIPPIN	G
פַ	be filed within 72 hours after death with the Maryland tal Hyglene. d other then "neturel", or items 23a or 28e-f show event, the Modical Examinan must be notified at	BeC	17. Father's Name (First, Middle, Last)		18. Mother's	Name (First, Middle, I		
Maryland	Men Men arke	To	JAMES BOWEN		MAR	RIE BENN	ETT	
Jar	2 sho						, City or Town, State, Zip	Code)
	1 and 3 Health em 27 other tr			1 ISAACS position (Name of	ROAD,	MIDDLE R		21220
Jou	Pages nent of H int: If ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	ematory or other plac	· 1		20c. Location - City or To	
altimore,	permit. Pag Department Importent: I eny injury o						BALTIMORE	
Ba	permit. Departr Importe eny inji			GILLY & 1	ZEILER TEDN A	R INC. FU	NERAL HOM	∃ > 21221
			23a. Part 1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.					Approximate Interval Between
1	Enysician		Immediate Cause (Final disease or condition	ins of	Kid	ne & Ca	ncer	Onset and Death
	/Medical Examiner		resulting in death)  Due to (or is a consequence of):		1 130	1107		
6		7	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):					
	uted I Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					
o,	exection and and rial-tra	Exa	resulting in death) Last  Due to (or as a consequence of):					
8760,	ficate be executed physician and is the burial-transit	dlcal	d					
9	ertifica ling ph e as t	Med	IF FEMALE:					
Box	leath certific attending p	ian/		□Ectopic pregnancy			23d. Date of delive Month	ry Day Year
о. О.	that the de ted by the a detached t	Physician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 9 ☐ Unknown 9 ☐ Unknown	Other (specify)				,
s, P	The law requires that the death certifi tle has been signed by the attending l age 2 should be detached for use as	by Pr	Part II. Other significent conditions contributing to death but not resulting in the	underlying cause give	en in Part I.	23e. Did tob	acco use contribute to th	e cause of death?
rds	w require been sig should b	ed b	1. Morbid obesity			1 □ Ye	s 2 No 3 Prob	ably 4 Unknown
Record	has be	Completed	2. Chronic lung disease			24a. Was ar autops	24b. Were autop	sy findings available
		Соп	J			perform 1 Yes 2	led? death? No 1 ☐ Yes	2 No
Vital	Physicien: Th rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?  Hospital:	Othe		Death Check on one	9	
_	sir dii	J.	1  Yes 2  No		4   14012111	g Home 5 Reside	nce 6 Other (Specify	)
on	nding Phy th. : After this s funeral c	tlon	1 Natural 5 Pending (Month, Day Year) Injury 2  Accident investigation	Work	(? Yes 2 □ No	200. Describe no	w injury occurred	
Division of	Atter or dea ector by the	ertification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm.	treet, factory, office		28f. Location (Str	eet and Number or Rural	Route Number,
	tal or	Cert	4 Homicide building, etc. (Specily)			City or Town	, 5(4(9)	Į.
	To the Hospital or Attending Pr within 24 hours after death. To the Funerel Director: After the completely filled in by the funera	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manufer stated.	ath occurred at the tim nvestigation, in my op	ne, date and pla pinion, death or	ace, and due to the ca ccurred at the time, da	use(s) and manner as state and place, and due to	ated. the cause(s)
	To ti To ti comp	M	29b. Signature and title of Centrier	29c. License	number	29	d. Date signed (Month, L	Day, Year)
			My 5 MM.	D175	543		12-01-04	
	3		30. Name and addr of person who completed cause of death (Item 23a) (Tyo	Print)	0 1	1 000	Dines	
			Stanley B. Silber mo 301 37 (2) 31. Date filed (Month, Day, Year) 32. Registrar's Signature	ul Place	[Da]	to INU	×1203	
	Sta Registr	13/11	12-01-04 ► DEC 1 4 200	14 Sere	~~ /	& Spar	Cal	

State of Maryland / Department of Health and Mental Hygiere 1 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 24 ELAINE **Physician** VislA December 9,2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Alvert Roomes IslAnd 5/60 Consent If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. | Month, Day, Year 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months Days 1□M 2XF 69 216-32-005 Yrs. Anch 291935 Director Usual Residence of Decedent 10d. Inside City Limits death with the Marylend 10c. City, Town or Location r than "natural", or itams 23a or 28a-f shor the Medical Examiner must be notified at 1 Yes 2 No alvent Director 10e. Street and Number 10g. Citizen of What Country? USA 2067 5/60 11. Marital Status DRIVE on sent Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc pemit. Pages 1 end 2 should be filed within 72 hours efter Department of Health and Mental Hyglene. Important: if item 27 is merked other than "natural", or ita my injury or other traumatic event, the Medical Examinary injury or other traumatic event, the Medical Examinary. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0020 Specify: HMERICAN ğ 3 Widowed 4 □ Divorced TICAL Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own 1246 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be lanche 19a. Informant's Na e/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Consent DR. Bloomes Ishn & Maryland 5/60 mela ROSS 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition

12 Burial 2 □ Cremation 3 □ Removal from State Zion 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatus of Funeral Service Licensee Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or bear failure. List only one cause on each line. Name and Address of Facility St. BAltimere, MARY And DIES Approximate Interval Between Onset and Death **Physician** 7 months Immediate Cause (Final disease or condition resulting in death) /Medical omce Emminer Due to (or as a consequence of) Physician/Medical Examiner inding physician and use as the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown signed by Completed by page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 5 Pending investigation 1 Natural 2 ☐ Accident efter death. Director: Aft 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours e Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) Medical within 24 hor To the Fune completely fi and manner stated 29d. Date signed (Month, Oay, Year) 29c. License number 29b. Signature and title of certifier 12.13.04 D 00 27189 ousar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Solomons Island Rd. HUNTINGTOWN Md. 20639 2417 LAhir YousAf 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

State

DEC 1 4 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Year 9:10 AM Alverta Dorsey Caldwell December 0 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Bull-more Sinau Hospital of Butimore 8. Date of Birth JAN. 15, 1922 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 214-18-7597 1 ☐ M 2 💢 F 82 Mary Land Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show or than "natural", or items 23a or 28a-f show the Medical Example must be political at 1 ☐ Yes 21 No Maryland Baltimore Director Gwynn Oak 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3308 Fieldview Road 21207 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No ģ Specify: Black 3√2 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4or 5+) Unk. Housekeeper Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fi and Mental H Joseph Dorsev Mary Smothers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 09 Pages 1 and 2 ment of Health a Janice C. Howard/daughter 3308 Fieldview Road Gwynn Oak, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State
4 Donation 5 Other (Specify) permit. Page Department o Importent: If any injury or once. Metro Crematory, Inc. 12/10/04 Baltimore, MD 21. Signature & Fur ral Service Licensee

Dawn F. McDonald <sup>22</sup> Name and Address of Facility
Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Wrosepsis /Medical Examiner Falure nal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) the attending physician and ned for use as the burial-transit certificate be executed Due to (or as a consequence of) Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 Yes Be Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ 100 elopolite autopsy performed? HTW 1 Yes 2 3 NO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Minpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 No Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Watural 28a. Date of injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 1 Cortifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

Box 68760.

DEC 1 4 2004

Kourissa

31. Date filed (Month, Day, Year)

Karissa Misner, D.O.

Misner

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Sinai Hospital of Baltimore

RES- PDD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend State of Maryland, Department of Health and Mental Hygiene 0 0 4 1 - For State Registrar 39478 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death :35 DECEMBER 2004 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Ltimore VA MediCAL CENTER BALtimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 1 1 M M 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Yrs. PEBRUARY 8 Usual Residence of Decedent 10b County 10c, City, Town or Location 10d. Inside City Limits NO Yes 2 No NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6610 Vincent Lane Apt 301 21215 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? ★★Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes XXNo Specify: Specify. 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Grounds Keeper Condo Complex na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Clayton Ella Hopes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6610 Vincent Lane Apt 301, Balto, Md 2
Date 20c. Location · City or Town, State <u> Millicent Clayton-Wife</u> Md 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Denation 5 ☐ Other (Specify) Garrison Forest Vet. 12/15/04 Owings Mills, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Pan 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of)

MIIFIAS PL Squardally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Cher (specify)

**Physician** /Medical Examiner

burial-transit

use as the

the attending physician and

signed by

peen

has certificate

this After this funeral of

after death

24 hours a

within 2

The law requires that the death certificate be executed

Hospitel or Attending Physicien:

Division of Vital Records, P.O. Box 68760,

permit Pages 1 and 2 sh Department of Health and Importent: if item 27 is m any injury or other treum once.

**Physician** 

/Medical

Examiner

Director

Funeral

Š

Completed

Be ဂ္ 10a State

MD

**Funeral** 

Director

Maryland

is 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene it has a feath and Mental Hygiene it is a 23 or 28a-f show other treumatic event, the Medical Everther must be notified as other treumatic event, the Medical Everther must be notified as

Baltimore, Maryland 21215-0036

Examiner Physician/Medical by Completed Be ( P

Certification:

Medical

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

VOLVULUS

1 ☐ Yes

2No 3 Probably 4 Unknown

24a. Was an autopsy performen? 1 Yes 2 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 2**X** No

25. Was case referred to medical examiner? examiner? 27. Manner of Deat 1 Natural 2 Accident

5 Pending investigation 6 Could not be determined

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28b. Time of Injury

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of cer

DEC 1 4 2004

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COLLINS, MD

ION. GREENE STREET BALTIMORE.

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature MR-ABRADA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierge 1 1 1.

			For State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of F rtificate of	lealth and Death		gierze 0 0 4	39479
	Physicia /Medic		Decedent's Name (First, Middle, Last Robert	Hudso	n	Clark	Sr.	2. Date of Dea Month	Day Year	3. Time of Death 3:00p.M
,	Examin Funeral Director		Social Security Number 6. Se	enter	(In yrs. last birthday) 88 Yrs.	4b. City, Town, o Pikesv  If Under 1 Year  Months Days		8. Date of Birth	4c. County of Dea	
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ecation				10d. Inside City Limits
	Mary B-f sho	tor	MD NA		Baltimo	re				1 X Yes 2 No
	vith the	Director	10e. Street and Number			10f. Zip Code		1	10g. Citizen of What C	•
	hs 23e	Funeral	3503 Abbie Plac	12. Was Decedent E	ver in U.S. 13.1		.244 Ispanic Origin? (S	Specify Yes or No-	U . S . A	
036	be filed within 72 hours after death with the Maryland Ital Hygiene. od other than "natural", or Items 23a or 28a-f show event, I're Medical Examinat mat be motified at	by	1 ☐ Never Married <b>¾</b> ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 ☐ Yes 2 ☒ N  If Yes, Give  Year or Dates:	0	If Yes, specify Cuba 1 ☐ Yes 2X No	an, Mexican, Puei Specity:	Specify Yes or No- no Rican, etc.)	Canaifu	
21215-0036	"natur	Completed	15. Decedent's Edu (Specify only highest grad	ucation de completed)	16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retired	pation during most of wo	orking	16b. Kind of Business	/Industry
712	e filed within al Hygiene. other than '	omp	Elementary/Secondary (0-12)  12th grade	College (1-4or 5-	+)	el Work			B <b>ethlehe</b> m	Steel
nd	be filed tal Hygi d other event, I	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,		
yla	2 should be and Mental Is marked (sumatic ev	2	Robert Banks Cl		40: 44:2		Marie I			
N N	コピアコ		19a. Informant's Name/Relationship (T) Ozenn Clark-Wif					Baltimo	r, City or Town, State, ore Md	Zip Code) 21244
Baltimore, Maryland	es t and 2 of Health fitem 27 r other tra		20a. Method of Disposition		20b. Place of Dispo		- 1		20c. Location - City or	
iii.	ment tant: If		1 N Burial 2 □ Cremation 3 □ I `4 □ Donation 5 □ Other (Specify,	)	King Me	morial	Park 1	2/17/04	Randalls	stown, Md
Bal	permit. Pages 1 and Department of Healt Important: If item 2' any Injury or other once.		0 300- 1 00	mond		Name and Addre larch F/ 1300 Wab	oash Ave	e, Balt:	imore, Mõ	21215
	I		23a. Part1. Enter the disease, or comp shock, or heart failure. List onty o Immediate Cause (Final	lications that caused ine cause on each line						Approximate Interval Between Onset and Death
S. C.	Physician / /Medical		disease or condition resulting in death)	a. Due to (or as a	consequence of):	AL IN	JARC	TION	1M	MGD, POTCE
	Examiner		Sequentially list conditions,	b						
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					
oʻ	execu an and rial-tra	Exa	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):					
68760,	tificate be executed g physician and as the burial-transit	edical		d						
.O. Box 6	requires that the death certific een signed by the attending p hould be detached for use as	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \text{Yes} \) 2 \( \text{No} \) 9 \( \text{Uhknown} \)	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t	☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)	/		23d. Date of de Month	livery Day Year
۵.	s that t ned by e deta	by Ph	Part II. Other significant conditions co	ntributing to death bu	t not resulting in the u	nderlying cause giv	ren in Part I.	23e. Did to	bacco use contribute to	o the cause of death?
ords	w requires been sign should be							1 🗆 Y	es 2.ĈNo 3⊟P	robably 4 Unknown
Il Records,	The law ate has b page 2 sl	Completed						24a. Was a autops perform	sy prior to	utopsy findings available completion of cause of
Vital	Physician: Th this certificate al director, pag	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatier		Oth	00	ath (Check only on		
on of	fter Ther	$\vdash$	27. Mann r of Death  1 Latural 5 Pending 2 Accident investigation	28a. Date of Injun (Month, Day	28b. Time o	f 28c. Injur	y at		ence 6 □Other (Spe ow injury occurred	city)
Division	e Hospital or Attendi 124 hours after death. 18 Funeral Director: A letely filled in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	ry - At home, farm, str (Specify)	reet, factory, office		28f. Location (Si City or Town	treet and Number or R n, State)	ural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C	29a. Certifier (Check only one)	vsician: To the best of iner: On the basis of and manner state	examination and/or in	h occurred at the tir vestigation, in my o	me, date and plac pinion, death occ	e, and due to the curred at the time, d	ause(s) and manner as late and place, and due	s stated. e to the cause(s)
	To th To th	Ž	29b. Signature and title of certifier	1	111	29c. Licens	enumber	2	29d. Date signed (Mont	th, Day, Year)
,	A.		the 10	who	2 (((1)	Di-M	11/5/4	0	DEC. 13	12004
-			30. Name and address of person who c	I G MD	atrymem 23a) (Type,	K. 14	to Ave	BA	TIM	HAS
	Sta	_	31. Date filed (Month, Day, Year)	32. Régistra	r's Signature	Spork	2	1		

			Please Ty Amend item#19	pe or Print i-b. 20a-c state of Mai	in Black II 22 perf yland/ Dep	ndelible h G839 partment	<b>ink</b> of H	Ensure 4/05 T ealth an	All Cop	ies A Hygid	ire Legi eβe∩ ∩	ble.	3948	3 0
		•	For State Registrar			ertificate					g. No.	-Y- (	7 7 7 (	
			1. Decedent's Name (First, Middle, Last)						2. Date Mont	of Death	Day	Year	3. Time of	
	Physici /Medic		Bernard Cronin						Dece		-	004	2:15	AM.
	Examin		4a. Facility Name (If not institution, give str				4	Location of D	Death		4c. County	of Death		
			Sinai Hospital		more	-		nore 1	City					
	Funeral Director		219-40-7360	7. Age	(In yrs. last birthda) 63 Yrs.	y) If Under Months	1 Year Days	if Under 24 Hours	Min. Sept	of Birth	T941	9. Birthpl Coun	ace (State o.	r Foreign unk
	uth with the Maryland 23a or 28a-f show 25a notified at	Į.	Usual Residence of Decedent  10a. State 10b. County  MD		10c. City, Town or Baltin						-	10	od. Inside Cil	
	28a-1	Funeral Director	10e. Street and Number			10f. Zip	Code			100	g. Citizen of V	What Coun	trv?	
	with with	ä	5411 Pembrooke Ave	nue			212	207			US			
	rs 23	era		. Was Decedent Ev	ver in U.S. 13	3. Was Deced	ent of His	spanic Origin	? (Specify Yes	or No-	14. Rac	e - Americ		
39	s 1 and 2 should be filad within 72 hours efter deeth with the Maryland if Health and Mental Hygiene. Itam 27 is marked other than "natural", or itam 1238 or 288-1 show itam 27 is marked other than "natural", or itam 28 notified at other traumatic event, the Medical Examiners	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	unk	If Yes, spec	•	n, Mexican, P Specify:	uèrto Rican, et	C.)		ck, White, o v: whi		
21215-0036	in 72 hou n "nature Medical E	Completed	15. Decedent's Educa (Specify only highest grade of	tion completed) College (1-4or 5+	(Giv	cedent's Usua ve kind of wor . DO NOT us	k done d	luring most of	working l	ınk 1	6b. Kind of B	usiness/Ind	lustry	unl
212	t within return the Mer	E	Elementary/Secondary (0-12) unk unk		,									
Maryland 2	uld be filad within fental Hygiene. rked othar than ' itc evant, the Me	To Be C	17. Father's Name (First, Middle, Last)				unk	18. Mother's	Name (First, M	liddle, Mi	aiden Suman	n <i>e)</i>		unl
ary	should and Men is marke	-	19a. Informant's Name/Relationship (Type	(Social W	lorker) A	du 1dere P	rote	ctive °	Service	un <b>(eg</b> u	ardia	ršfri79	Wit)	9
	and 2 Balth a n 27 is			Okye	20b. Place of Dis						21775 oc. Location	2, MD	21215	ě
aitimore,	8° 5 7 7		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Rei  4 ☐ Donation 5 📆 Other (Specify)	noval from State	cemetery, cr	position (Nan rematory or o	ne of ther place	9)	Dafe	20	Oc. Location -	City or To	wn, State	
aiti	permit. Pa Depertmer Important any injury		21 Signatura (Veuneral Service Licensee	ale		22. Name an	d Addres	s of Facility	Joseph	Ļ, R	uss Fu	mera	L HOme	
Õ	Depermine permine	Jensey S. W	//////	100/1	52 1 100	11 (2)	(VIII) /	17111 777	O T.T	NT1	Ave.	Balt	imore	
	Physician		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one Immediate Cause (Final disease or condition	tions that caused to cause on each line	he death. Do not e	enter the mod	e of dying	g, such as car	rdiac or respira	ory arres	M STS	LO	Approximate Interval Betto Onset and E	ween Death
	/Medical Examiner		resulting in death)		consequence of):		10011	010.01				'	111011	
	rted nsit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):									
68760,	certificate be executed nding physician and use as the burial-transit	dicai Examin	that initiated events resulting in death) Last c.	Due to (or as a	consequence of):									
Box	death certifies attending	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9  Unknown	e. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death	3 □Ectopic pr 5 □ Other (sp						te of delive		/ear
P.O.	that the de ned by the a		Part II. Other significant conditions conti	ibuting to death but	t not resulting in the	underlying c	ause give	en in Part I.	23e.	Did toba	acco use con	tribute to th	e cause of d	eath?
rds	w requires that s been signed t should be det	d by	Hypertension, Di	abetes 1	Vellitus	, Chi	onic			1 Yes	2 □ No	3 🗌 Prob	ably 4 □L	Jnknown
of Vital Records,	ela has	Completed	Obstructive Pulmo	nary Di	sease				24a.	Was an autopsy perform	ed3/	prior to cor death?	osy findings and pletion of ca	available ause of
tal		O	25. Was case referred to medical					26. Place of	Death (Check			103	2,00	
>	o p	0	examiner? 1 ☐ Yes 2 ☑ No	spital: 1 Inpatien	t 2 ER/Outpat	ient 3 DC	A Othe	er: 4 Nursi	ng Home 5	Residen	nce 6 Oth	ner (Specify	")	
	After	ition: T	27. Manner of Death 1 DNatural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day	Year) 28b. Time		8c. Injury Work	/ at <br Yes 2 □ No		cribe hov	v injury occur	red		
Division	i or Attendi after death. Director: A d in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	ry - At home, farm, (Specify)	street, factory	, office			tion (Stre or Town,	eet and Numl State)	ber or Rura	l Route Num	ber,
	To the Hospital or Attending within 24 hours after death. To the Funaral Director: Attencompletely filled in by the fune	edicai C	29a. Certifier 1  Certifying Physic (Check only one) 2  Medicel Exemine	cian: To the best of er: On the basis of and manner stat	examination and/or	eath occurred investigation	at the tim , in my op	ne, date and p pinion, death	place, and due to occurred at the	o the cau time, dat	use(s) and mate and place,	anner as st and due to	ated. the cause(s	)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		0			e number			d. Date signe	,		,
			30. Name and address of person who con	man of de	ath (Item 23a) (Tvo		LES-	-000			recemb			
	C4	atė	Eileen S. Zingmay 31. Date filed prop Dry 4002004		2401		Belvi	edere	Balti	mor	e,M	D 21	215	
	- 30	-116	DEO T 5004	100	1	1	63							

State Registrar

		1	For State Registrar		State of Ma	ryland / De	partment of I certificate of	Health and <i>Death</i>		Reg.		ļļ.	394	
н	Physicia		1. Decedent's Name (First	t, Middle, Last)		<			Mo	te ot Death onth cembei	Day	Year 2004	3. Time (	
	/Medic	al -	4a. Facility Name (If not in	estitution give si	reet and number)		4b. City, Town,	or Location of De		CETTIOE	4c. County			
	Examin	er	Johns Hopki	ins Bay	view Med	ical Cente	r Baltin	nore						
E	Funeral Director		5. Social Security Number 215-10-4255	6. Sex	M 2∏ F 7. Age	(In yrs. last birtho	Months Days		tin. (Mo	te of Birth onth, Day, Ye ril 3,	1919	9. Birthp	olace (State otry) MD	or Foreign
	and w	-	Usual Residence of Deced 10a. State 10b.	County		10c. City, Town o	r Location					1	0d. Inside (	City Limits
:	Mary 1-1 sho	tor	MD. Ba	altimore	e	Dun	dalk						1 🗋 Ye	s 2 <b>X</b> No
	or 28s	Olrec	10e. Street and Number	_			10f, Zip Code	24222		10g.	Citizen of V		ntry?	
	sath w	Funeral Director	103 Center I		2. Was Decedent B	ver in U.S.	13. Was Decedent of	21222 Hispanic Origin?	? (Specify Ye	es or No-	14. Rac		can Indian,	
2-00-0	of within 72 hours after death with the Maryland speed. It than "neturel", or Itams 23a or 28a-f show the "marite rivilled at the Medical Exertion must be rivilled at	þ	1 ☐ Never Married 2 3 ☑ Widowed 4 ☐ D	2 Married	Armed Forces?  1 Yes 2 N If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Cui		uèrto Rican,	etc.)	Specify	ck, White, V: Wh	etc. ite	
ဂ ဂ	72 ho "natur	Completed		Decedent's Educ ly highest grade		1 (0	ecedent's Usual Occu Give kind of work done fe. DO NOT use retire	during most of	working	168	b. Kind of B	usiness/In	dustry	
7	within ene. than	dwa	Elementary/Secondary 12 years	(0-12)	College (1-4or 5	+)	Account Ma			Ma	arine	Pain	t Com	pany
פ	e filed othe vent,	Be C	17. Father's Name (First,	Middle, Last)				18. Mother's i		, Middle, Mai				
yland		ToE	Henry Prion						n Col		Maria Tarra	Ctata 7	- Codel	
=	2 S S S S S S S S S S S S S S S S S S S		19a. Informant's Name/R Carolyn Jone		Daughter		Mailing Address (Stree  6 Dunmore					State, Zij	(0000)	
ຜົ	Ø O		20a. Method of Dispositio	n mation 3 R		20b. Place of D	isposition (Name of crematory or other pl		Decemb 7, 200	er	c. Location -			
Baltil	permit. Page Department ( Important: If any Injury or once.		21. Signature of Funefal		· Con	reller	Connelly 7110 Sol						_	
			23a. Part1. Enter the dis- shock, or heart failu	ease, or compli	cations that caused e cause on each lin	the death. Iso no	enter the mode of dy	ring, such as care	diac or resp	ratory arrest			Approxim Interval B Onset and	etween
9	Physician		Immediate Cause (Final disease or condition resulting in death)		Seps	is							4 d	01 7 S
	/Medical Examiner		resutting in death)			a consequence of	cellulitis	5					70	lays
Ġ,	(*	Jer	Sequentially list condition if any, leading to immedia	ns, ate	Due to (or as	a consequence of	:							
	icate be executad physician and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		. Due to /or as	a consequence of								
58760,	be exician a	al E	,	ı,	Due 10 (01 as	a consequence of	•							
	ificate g phys as the	edical												
). Box	Hospital or Attending Physician: The law requires that the death certifically hours after death. Funeral Director: After this certificate has been signed by the attending of riely filled in by the funeral director, page 2 should be detached for use as it	Physician/M	IF FEMALE: 23b. Was decedent preg in the past 12 monti 1  Yes 2 No	nant	3c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal death	3 ☐Ectopic pregnan 5 ☐ Other (specify)	су				ate ot deliv onth	ery Day	Year
P.O.	that the		9 ☐ Unknowň * Part II. Other significant	conditions cor	tributing to death b	ut not resulting in	he underlying cause o	given in Part I.	2	3e. Did toba	cco use con	tribute to	the cause o	f death?
ds,	uires l signe	d by	diabete	5 60	lovesic	ular fi	stula			1 🗆 Yes	2 🗆 No	3 🗌 Pro	bably 4	Únknown
Records,	aw require is been sig 2 should b	Completed	urinary	tract	infect	ion			_ 2	4a. Was an autopsy	ļ	prior to co	opsy finding	s available cause of
<u> </u>	The late happened	Com	9						1	performe ☐ Yes 2 ☐	d? ▼No	death?	2 🗆 No	
Vita	Iclan: certific ector,	Be	25. Was case referred to examiner?	-	lospital:		-7-0.	)thon		ock only one)		(0	Y. A	
of	Phys ir this oral dir	.: To	1 X Yes 2 No 27. Manner of Death		28a. Date of Inju		ne ot 28c. In	jury at		S Residend Describe how			ny)	
o	nding th. Afte	atlor	2 Accident	Pending investigation	(Month, Da	y rear) in		lork? □Yes 2□No						
Division of Vital	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Cer ification;	3 Suicide 6 4 Homicide	Could not be determined	28e. Place of Inj building, et	ury - At home, fan c. (Specify)	n, street, factory, offic	8	28f. L	ocation (Stre lity or Town, .	et and Num State)	ber or Rui	al Route Ni	ımber,
	he Hospi n 24 hour ha Funer pletely fille	edical	29a. Certifier 1 (Check only one)	Certifying Phy Medical Exami	sician: To the best ner: On the basis o and manner st	f examination and	death occurred at the for investigation, in my	y opinion, death o	place, and di occurred at	the time, date	e and place,	and due	to the cause	
	withi Tot	Σ	29b. Signature and title				_	nse number Res - 0 (	00		1. Date signe			
,	1.		Occord		ampleted cause of 6									
	10		Deborah C	ummi	ns, Mo;	BMC,	Eastern	Avenu	e, Bo	altime	re 1	10	2122	24
		ate	31. Date filed (Month, Da	ay, Year)	32. Registi	rar's Signature	A							
DH	Regist	-	DEC 1	1 4 2004	Bene	per B	Spork							

DHMH 17 Rev 1/2001

ORIGINAL

		-	For State Registrar	of Maryland / Dep Ce	ertificate of D	alth and M <i>eath</i>	lental Hygie Rag.	WAR 12 -	39482
	Physicia		Decedent's Name (First, Middle, Last)					Day Year	3. Time of Death
	/Medic	al -	Heber H. Culp				DECEMBER	11, 2004	6:19 PM
ı	Examin	er	4a. Facility Name (If not institution, give street and Saint Joseph Medi	.cal Center	4b. City, Town, or L	Tows	on		imore
	Funeral Director		5. Social Security Number 6. Sex 1 № M 2 □	7. Age (In yrs. last birthday F 84 Yrs.		Hours Min.	8. Date of Birth (Month, Day, Ye July 25,	ear) Coui	place (State or Foreign htry) Virginia
	pu *	-	Usual Residence of Decedent  10a, State 10b, County	10c. City, Town or I	ocation			1	0d. Inside City Limits
	Aaryla f sho	5	MD N/A	Balti					1 Yes 2 □ No
	the the 28a-	Director	10e. Street and Number		10f. Zip Code		10g.	. Citizen of What Cour	ntry?
	h with		5113 Pembroke Avenue		21206			U.S.A.	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic evant, the Medical Exertic net must be notified at or other traumatic.	by Funeral	1 Never Married 2 Married 1 MY	d Forces? es 2 ☐ No s. Give	. Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 ☐ No	panic Origin? (Sp Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:	
8	hour itural	ed b	15. Decedent's Education	or Dates: 1945	edent's Usual Occupati	on	161	b. Kind of Business/In	
75	n na	Completed	(Specify only highest grade complete	ted) (Giv	e kind of work done du DO NOT use retired)	ring most of work	ring		,
212	d with giene	E	12	ge (1-401 3+)	Owner			Ory Cleani	ng Store
Maryland 21215-0036	al Hyg	Be C	17. Father's Name (First, Middle, Last)		1		e (First, Middle, Mai		
ylaı	should be fand Mental is marked of	2	Grant P. Culp				irginia E		
<u>lar</u>	2 shot and last last many raum		19a. Informant's Name/Relationship (Type, Print)		ling Address (Street an				
e)	1 and Health em 27 ther tr		Mr. Dale D. Culp- Son	20b. Place of Disc	Breezenick		The second second	c. Location - City or To	
יסר	Pages nent of h int: If ite iry or of		1 X Burial 2 ☐ Cremation 3 ☐ Removal f	cemetery, cr	ematory or other place)   Baptist C			ereford, Ma	
Baltimore,	permit. Pages 1 and 2 Department of Health s Important: If item 27 It any injury or other tra once.		'4 □Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee		22. Name and Address	of Facility Lec	onard J. F	Ruck, Inc.	
	20 E 4 0		23a. Part1. Enter the disease, or complications to	hat caused the death. Do not e	5305 Har	ford Roa	d Baltimo	ore,MD 212	1 /1 Approximate
П			shock, or heart failure. List only one cause	on each line.					Interval Between Onset and Death
	Pnysician /Medical		disease or condition a. Kb	ECURRENT STATE to (or as a consequence of):	BE IV NON	SMALL	CELL CF	NCER OF	
Н	Examiner			LUNG					
		Je .		e to (or as a consequence of):					
17	cuted od ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c						<u> </u>
o,	e exerian ar		resulting in death) Last Du	e to (or as a consequence of):					
8760,	the death certificate be executed y the attending physician and tched for use as the burial-transit	dlcal	d						
9	eath certific attending p	/Mec	IF FEMALE: 23c If yes	, outcome of pregnancy				22d Data of dalay	on.
Box	aath c attenc for us	Physician/Me	in the past 12 months?	ive birth 2 Fetal death 3	☐Ectopic pregnancy			23d. Date of deliv Month	Day Year
o.	that the de ed by the detached	iysid		Jnknown	- Carron (apoonly)				
σĹ		by Ph	Part II. Other significant conditions contributing	to death but not resulting in the	underlying cause given	in Part 1.	23e. Did tobac	cco use contribute to t	he cause of death?
rds	requires that een signed b nould be deta						1X Yes	2 No 3 Prof	oably 4 Dunknown
Records	> 9 5	Completed					24a. Was an autopsy	24b. Were auto	opsy findings available ompletion of cause of
	The te h age	E					performe 1 ☐ Yes 2 🔯	d? death?	
Vital	sician: certifica rector, p	Be C	25. Was case referred to medical examiner?		(	26. Place of Deat	th (Check only one)		
ž V	Physician: this certific ral director,	2	1 ☐ Yes 2 📉 No	1 X Inpatient 2 ER/Outpati		4 🗀 Nursing no		ce 6 Other (Special	(y)
n c		lon:	1 X Natural 5 ☐ Pending	Date of Injury 28b. Time (Month, Day Year) 1njury	Work?	at es 2 □ No	28d. Describe how	injury occurred	
isio	Attending r death. actor: After	icat	2 Accident investigation 3 Suicide 6 Could not be	Place of Injury - At home, farm,		95 2 110	28f. Location (Stree	et and Number or Run	al Route Number.
Division of		Certification:		building, etc. (Specify)	stroot, izotory, onice	1	City or Town, S		,
	To tha Hospital or within 24 hours afte To tha Funaral Dircompletely filled in	edical C	(Check only 2 Medical Exeminer: On	o the best of my knowledge, de the basis of examination and/or manner stated.	ath occurred at the time investigation, in my opi	e, date and place, nion, death occur	and due to the caus red at the time, date	se(s) and manner as s a and place, and due t	stated. o the cause(s)
	To tha within 2 To tha complet	Me	29b. Signature and title of certifier	MI	29c. License	number	29d	. Date signed (Month,	Day, Year)
	- >- 0		1 Conothe For	UMaD,	p 24	Ø34		12/11/6	9
•	1		30. Name and address of person who completed	cause of death (Item 23a) (Typ	e, Print)			1	
	6+1		TIMOTHY LOW, M.D.	7601 OSLER		OWSON,	MARYLAN	D 21204	
	Sta	ate rar	31. Date filed (Month, Day, Year) BEC 1 4 2004	3. Registrar's Signature	realed				

Amend Trem 10b, dint in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier () 39483 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 10;07 PM Conley 4 04 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Rehabilitation Extendal care Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1**⊠**M 2□F 55 27, Director 213-52-1213 Dec Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits item 27 is marked other than "neturel", or items 23e or 28e-1 show other treumetic event, the Medical Examinar must be notified at Arundel Anne 1 1 Yes 2 No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21225 105 1st Avenue United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Kayes 2 □ No 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: VIETNAM 1 ☐ Yes 2 X No Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Automobile Supply Elementary/Secondary (0-12) College (1-4or 5+) Delivery Man 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental Linzie Raymond Conley Opal Lenore Slone 19a. Informant's Name/Relationship (Type, Pr Cathleen Conley\_/ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health at
Importent: If item 27 Is
any injury or other treu 105 1st Avenue, Baltimore, MD 21225 Catherine 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Dec 13 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Beltsville, MD 2004 \* 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation and Funeral Alternatives M00086 8717 Green Pastures Drive Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
UM Known Immediate Cause (Final **Physician** -arcinoma disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Under, in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1□Live birth 2□Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 1 No 3 ☐ Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 Z No 1∏ Yes Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes 2 ▼ No 1 Inpatient 2 ER/Outpatient 3 DOA Other: 2 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manper of Death 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 2 No investigation after death Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel L to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 34359 (0H10) 12 Name and address of person who completed cause of death (Item 23a) (Type, Print) Idas. LAH, m.D. 3 900 Lock Roven Boulevard, Baltimore, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

		1	For State Registrar		State o	f Marylar	-	artment of Hartificate of L		nd Me		200	and the	39484
	0		1. Decedent's Name (First,	Middle, La	ast)				*.	2	. Date of Death Month	Day	Yeer	3. Time of Death
	Physicia /Medic		ALEX R.	CHIE	RF.					1	December	-	2004	7:00 PM
	Examin		4a. Fecility Name (If not ins			n <i>ber)</i>		4b. City, Town, or		Death		4c. County		
		ш	Silvai Hos	pital	of Ba	1 timore		B-1+	-				Cit	У
	Funeral Director		5. Social Security Number 220-64-8077	6.	Sex XXM 2□F	7. Age (In yrs. 5		If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Min.	Date of Birth (Month, Day, Y) Jan. 29,	1954	Cour	place (State or Foreign ntry) 1to. Md.
	pur *	}	Usual Residence of Deced 10a. State 10b. C	ounty		10c. Cit	ty, Town or Lo	cation					1	0d. Inside City Limits
	Aaryla	ь	Md.		ltimore	1.23.21		erstown						1 ∐ Yes 2 ∐XNo
	28a-1	ect	10e. Street and Number	Ба	TCIMOLE		Reiste	10f. Zip Code			100	. Citizen of V	/bat Cour	ntov?
	with Ma of	₫						21136				,		SA.
	ns 23	era	10 Falls Cha	apel	12. Was Deci	edent Ever in U	.S. 13. V	Vas Decedent of Hi	spanic Origin	n? (Specif	fy Yes or No-	14. Race		can Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Marical Exal is at most be notified and once.	by Funeral Director	1 Never Married 25	_	Armed Fo	2 [X]No /e	1	fYes, specify Cuba 1 □ Yes 2 🔀 No	n, Mexican, F Specify:	Puerto Rio	can, etc.)	Specify	k, White, : Whj	
O	2 hou	ed		cedent's E	Education			ient's Usual Occupa			16	ib. Kind of Bu		
21215-0036	within 7% ene. than "na	Completed	(Specify only Elementary/Secondary (I		College (	1-4or 5+)	Groc	kind of work done d DO NOT use retired,	uring most o	f working		Racetr	1_	
	Hyg Hyg other ent,	a)	17. Father's Name (First, M	fiddle, Las	st)			JIIC I	18. Mother's	s Name (F	First, Middle, Ma			
Maryland	lid be lental ked ic ev	To B	Alex Chire						Marga	ret (	Celette			
ary	shou and M s mai		19a. Informant's Name/Re	lationship	(Type, Print)		19b. Mailir	ng Address (Street a				City or Town,	State, Zip	Code)
	and 2 alth a		Patricia L.	Chir	e			ills Chape		Reis	sterstov	m , M	211	.36
Baltimore,	of He fitem		20a. Method of Disposition	ation 3	□ Removal from	State 20b. F	Place of Dispo cemetery, cren	sition (Name of natory or other place	9)	Date	θ 20	c. Location -	City or To	own, State
Ĕ	Pag ment ant: I ury o		'4 □Donation 5 □O				rroll (	rem. Ser.	. 12	/14/2	2004 На	ampstea	ad. M	Maryland
3alt	Depart Import Import any inj		21. Signature of Funeral S	ervice Lice	ensee			. Name and Addres			1824 Rei			
	20 E 6 0		Jams	7 (	Jun	e							lary1	and 21136
		4	23a. Part1. Enter the disease shock, or heart failure	ase, or cor e. List only	y one cause on e	ach line.				irdiac or r	espiratory arres	t,		Approximate Interval Between Onset and Death
	Pnysician /Medical	8 1	Immediate Cause (Final disease or condition resulting in death)		a	Myoc	ardial	Infarct	ion					
1	Examiner		,	ſ	Due to	(or as a consec	uence of):							
		Jer	Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Discose or in jury)		b. Due to	(or as a consec	quence of):						-	0.50.5
VIT	cuted	Examiner	that initiated events	-1	c									
Ö,	icate be executed physician and s the burial-transit	Ex	resulting in death) Last		Due to	(or as a consec	quence of):							
8760,	ate be hysici	dlcal		•	d									
9	e as	a	IF FEMALE:				7.77							
Вох	death certifi e attending d for use as	lan/	23b. Was decedent pregna in the past 12 months		1 Live b	tcome of pregna pirth 2 Teta nant at time of c	al death 3	Ectopic pregnancy Other (specify)				23d. Dat Mor		ery Day Year
o.	ires that the death certific signed by the attending F d be detached for use as	Physician/M	1 □ Yes 2 □ No 9 □ Unknown		9☐ Unkn		ieaui 5	Other (specify)						
Д	requires that the een signed by thi rould be detache	y Ph	Part II. Other significant c	onditions	contributing to d	eath but not res	sulting in the u	nderlying cause give	n in Part I.		23e. Did toba	cco use contr	ibute to th	ne cause of death?
rds	quires n sign	d by								_ !	1 ☐ Yes	2 🗆 No	3 🗌 Prob	ably 4 Ninknown
Records,	> 0 to	Completed									24a. Was an	24b. V	Vere auto	psy findings available
Re	9 L 6	шо									autopsy performe 1 ☐ Yes 2 🗓	d?   d	rior to co leath? Yes	mpletion of cause of
Vital		Be C	25. Was case referred to r	nedical					26. Place of	f Death (0	Check only one)	3110		
of V	9 (4)	To E	examiner? 1 ☐ Yes 2 🕱 No		Hospital: 1	Inpatient 2	ER/Outpatien	t 3 DOA Othe	or: 4 🗆 Nursi	ing Home	5 Residence	e 6 Othe	er (Specif	y)
o u			27. Manner of Death 1 Natural 5	Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	28c. Injury Work	at ?	280	d. Describe how			
sio	Attending r death. sctor: Afte	catl	2 Accident	investigation	he				res 2 □ No	-				
Division	tal or At s after d al Direct ed in by	Certification:		determine	d 28e. Place	of Injury - At h ing, etc. <i>(Speci</i>	ome, farm, str fy)	eet, factory, office		281	City or Town,		er or Rura	il Route Number,
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edical (			eminer: On the b			occurred at the time vestigation, in my op						
	To the within 2 To the complet	Me	29b. Signature and title of	certifier				29c. License	number		29d	. Date signed	(Month,	Day, Year)
			25	2	$\leq$	> M.C		Δ0	59062	2	Δ	ccembe	8	2004
	6		30. Name and address of p	an dan	completed caus	se of death (Item	m 23a) (Type,	Print)	100	Ba	enite		,	
:	Sta		31. Date filed (Month, Day			tegistrar's Sign			* 1					
	Regist	ar	DEC	14	2004	Ruse year		payer						

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Baitimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland	Department of Health and Mental Hygiene.	Important; if item 27 is marked other than "natural", or itema 23a or 28a-f show	any injury or other traumatic event, the Medical Exertical Legislat Legislied at

		1 Degistrer	- (Fina Minhita I -	-41					2. Date of D	Joseph .		2 Time of Dooth
Physicia	n		ne (First, Middle, La					,	Month	Da		3. Time of Death 4 5:45 AM
/Medić		John A					41. Oh. T-		DECEMBE		1, 200	
xamine	er			e street and number) Medical	Cente		4b. City, Towr	n, or Location of Dea Tow		40	County of Dea Bal	timore
							If Under 1 Ye			liab.	0 P:-	theless (Carte ex Ferri
eral		5. Social Security		ØX 2□F 7. Ag	e (In yrs. last. 85		Months Day			Day, Year 101	Q Mar	thplace <i>(State or Foreigi</i> ountry) <b>y l and</b>
ctor	-	213-14- Usual Residence			00				Apr 0	, 131	Jilai	yrand
umatic event, the Medical Ever graf intal Researchines at	1	10a. State	10b. County		10c. City, To	own or Loca	ition					10d. Inside City Limits
	ō	MD	Baltimor	^	Reist	oreto	wn					1 ☐ Yes 2 No
	Director	10e. Street and No		<u> </u>	Keist	E1 3 CO	10f. Zip Cod	Α		10g. Ci	tizen of What Co	ountry?
	<u></u>		estnoll R	oad			21136			USA		Surviy :
ål	Funerai	11. Marital Status	C3 (110 11 1K	12. Was Decedent	Ever in II S	13 W		of Hispanic Origin? (	Specify Ves or N		14. Race - Ame	erican Indian
	5		ried 2 Married	Armed Forces?		if.	es, specify C	uban, Mexican, Pue	rto Rican, etc.)		Black, Whi	
	by	_	4 XDivorced	Il Yes, Give Year or Dates:	10	1[	□Yes 2🔯 i	No Specify:			Specify: W	hite
			15. Decedent's Ed		16	6a. Decede	nt's Usual Oc	cupation		16b. K	(ind of Business	
	Completed		cify only highest gra	ide completed)		(Give ki	nd of work do NOT use rel	ne during most of w rired)	orking			
	Ë	Elementary/Sec 12	ondary (0-12)	College (1-4or 5	<sup>(+)</sup> P	resid				J&A	Contra	cting Co.
		17. Father's Name	(First, Middle, Last,	)				18. Mother's Na	me (First, Midd			
	o Be	Frank J	. Corasan	iti				Anna	Capezi	0		
	၉	19a Informant's i	Name/Relationship (	Type Print)	1	9h Mailing	Address (Stre	eet and Number or F	Tural Boute Num	ther City	or Town State	Zin Code)
	-									-		
once.	ł	20a. Method of Di		iti, II /			restno tion (Name of	11 Road;	Date		ocation - City or	
		1 ☐ Burial 2	Cremation 3	Removal from State	ceme	tery, crema	itory or other i	Corp. 12,	116/04	_		
			5 Other (Specif		niii	<del></del>			10/04	1	son, MD	
		21. Signature of F	Ineral Service Lice	nsee )		22.	Name and Ad	dress of Facility			050 York	
	_		Chr. V.C	ling				on Funera		To	owson, M	The second secon
п		23a. Part1. Enter shock, or he	the disease, or com art failure. List only	plications that caused one cause on each li	the death. D	o not enter	the mode of o	dying, such as cardi	ac or respiratory	arrest,		Approximate Interval Between
١		Immediate Cause disease or condit		CONGES	STIVE	HEAF	T FAI	LURE				Onset and Death YEARS
r		resulting in death	•	Due to (or as	a consequence	ce of):						
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Į	ner	Sequentially list of any, leading to cause. Enter Und Cause (Disease of	immediate	Due to (or as	a consequenc	ce of):						
	Examiner	Cause (Disease of that initiated even	or injury	c.								
	EX	resulting in death	) Last	Due to (or as	a consequenc	ce of):						
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	an/Medical	IF FEMALE: 23b. Was decede	nt pregnant	23c. If yes, outcome 1 Live birth	of pregnancy	2 🗆 E	atania negana	201			23d. Date ol de	
		in the past 1 1 Tes 2		4☐Pregnant at			Other (specify,				Month	Day Year
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	by P	Part II. Other sign	ificant conditions	contributing to death b	ut not resultin	g in the und	erlying cause	given in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
									1 [	Yes 2	□No 3□P	robably 4 Unknown
	Completed								24a. W	is an	24h Were a	utopsy findings available
	m D								aut	opsy formed?	prior to death?	completion of cause of
									1 ☐ Yes			2 No
	Be	25. Was case rele examiner?		Hospital:			T	Othor	eath (Check onl)			
	2		No	1 Ninpatie	ent 2 ER/		3LI DUA	4   Nursing			6 ☐ Other (Spe	ocify)
	OU	27. Manner of Dei	5 Pending	28a. Date of Inju (Month, Da	y Year)	b. Time of Injury	\	Nork?	28d. Describ	e now inju	iry occurred	
	cat	2 ☐ Accident 3 ☐ Suicide	investigatio 6 ☐ Could not b					Yes 2 No				
	Certification	4 Homicide	dotomiood			, farm, stree	et, factory, offi	ce	28f. Location City or T	(Street all own, State	nd Number or R e)	ural Route Number,
	edicai	29a. Certifier (Check only	Certifying Pl	nysicien: To the best miner: On the basis o	of my knowled f examination	dge, death of and/or inve	stigation, in m	e time, date and place to time, date and place	e, and due to the	e cause(s	and manner and place, and due	s stated. e to the cause(s)
	led	one)		and manner st	ated.							
	Σ	29b. Signature an	( )	Do bi			29c. Lic	ense number			ate signed (Moni	1)
		. Lond	inder P	mella 1	n.0		DA	1410		Dec	inhor )	110 2 woll.
		30. Name and add	dress of person who	completed cause of d	leath (Item 23	a) (Type, P	rint)					
		TOSTNI	ER P. M	EHTA. M.	n 74	501 (	ISI ED	DRIVE	TOUSON	MO	RYLAND	212014
Sta	1	31. Date filed (Mo			ar's Signature		n bur bun bun I. l.	and to take William	A Secretary Section 19	1,173		man on the bay Bay. 4

DHMH 17 Rev 1/2001

State Registrar

DEC 1 4 2004

ORIGINAL

			For State Registrar		State o	of Ma	ryland	d / Dep <i>Ce</i>	artmen	t of H	ealth a Death	and M	lental Hy	gien Reg. N		004	39	486
			Decedent's Name (First, M.	liddle, Last)							10		2. Date of De	ath	ay	Year	3. Time	of Death
	Physicia /Medic	al	Joseph Ant		Costa								Decemb	er	8,	2004	ــــــــــــــــــــــــــــــــــــــ	56 P M
	Examin	er	4a. Facility Name (If not insti Greater Balt				Cente	er		Town, or COWSO	Location o	f Death		4	c. Coi	unty of Deatl Balti		
	Funeral Director		5. Social Security Number 219-18-5940	6. Sex	M 2□F	-	(In yrs. la	ast birthday Yrs.	Months	1 Year Days	If Under 2 Hours		8. Date of Bir March	th 1/9 Year	192	9. Birtl		te or Foreign ryland
	and w		Usual Residence of Deceder 10a. State 10b. Co				10c. City	, Town or L	ocation								10d. Inside	City Limits
	Maryla f sho	tor	MD N/A	,			Balt	imore										es 2 □ No
	r 28e	Irec	10e. Street and Number						10f. Zip					-		of What Co	untry?	
	23a c	ral D	4906 E. Fede	al St	reet				21	205				USA	\			
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "netural", or items 23s or 28e-1 show any injury or other treumetic event, the Medical Evaninal be notified at once.	by Funeral Director	11. Marital Status  1 Never Married 2 3 Widowed 4 Divo	Married	<ol> <li>Was Dec Armed Find Yes</li> <li>1 ☐ Yes</li> <li>If Yes, Gint Year or I</li> </ol>	orces? 2 ☑ N ive		5. 13.	Was Deceded of Yes, specifical Yes, specifical Yes	cify Cubar	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	-		Race - Ame Black, White ecify:		•
5	72 hou			dent's Educ				16a. Dece	edent's Usu	al Occupa	ation	of worki	ng:	16b.	. Kind of Business/Industry			
7	ithin 7 Je. Jen "r	Completed	(Specify only h		College (	-	+)	life.	Emplo	se retired)	)	OI WOIKI	ng .	C 1	00	Repre	conta	tivo
7	iled w Hygier ther th		17. Father's Name (First, Mic					Seri	Ellih 10		18 Mothe	r's Name	(First, Middle			·····	Senta	tive
<u></u>	ould be filed with Mental Hygiene arked other the etic event, Ire I	To Be		stanz	a						Jeane			itan				
2	2 should and Mer Is marke eumetic	Ĕ	19a. Informant's Name/Rela	ionship <i>(Typ</i>	e, Print)			19b. Mail	ing Address	(Street a	nd Numbe	r or Rura	I Route Numb	er, City	or To	wn, State, Z	ip Code)	
, M	t and 2 Health a om 27 is		Reita Costan	za	/ wi	fe_		4906	E. F	edera	al St	reet	; Balti	mor	e,	MD 21	205	
	Pages 1 ament of He ent: If iten ury or oth		20a. Method of Disposition  1  Burial 2 Crema 4 Donation 5 Oth	ion 3 □Re or (Specify)	entombn	State <b>ent</b>	Ce	ace of Disp ometery, cre ney Val	matory or c	ther place	dens :		/04			on - City or ium, M		
מו	permit. Page Department of Importent: If any injury or once.		21. Signature Funera Ser	01	Que			R	2. Name ar uck T	owsor	n Fun	eral		Т		O York son, M		
			23a. Part1. Enter the diseas shock, or heart failure.	e, or complic List only one	ation that e cayseron	caused each line	the death. e.	. Do not er	iter the mod	le of dying	g, such as	cardiac d	r respiratory a	rrest,			Approxir Interval	nate Between nd Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a.	M	M	sca	rde	al	M	for	cti	M				O11361 a1	
	/Medical Examiner		resulting in doday		Due to	(or As a	consequ	ence of):	0	Let	11 7	0,1	0110					
		ler	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs Disease or injury	b.	Due to	(or as a	consequ	ence of):	W	(10-	J	u p	car					
	cuted od ransit	Examiner	that initiated events	C.												9		
Š	cate be executed physician and the burial-transil	I Ex	resulting in death) Last		Due to	(or as a	consequ	ence of):										
00/00	cate b physic the b	dlcal	d								-							
O. DOX O	To the Hospitel or Attending Physicien: The law requires that the death certific within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1  Yes 2 No 9 Unknown	23		birth 2 nant at t	of pregnar 2 Fetal time of de	death 3	□Ectopic pi □ Other (sp						23d.	Date of deli Month	very Day	Year
ŗ	s that I	by Ph	Part II. Other signiffcant co	ditions cont	tributing to d	leath bu	t not resu	Iting in the	underlying o	ause give	n in Part I.		23e. Did t	obacco	use c	contribute to	the cause	of death?
	quires an sign		Cerema	l b	escu	la	1	aus	e and	9			10	Yes 2	2 🗆 N	o 3□Pro	bably 4	Onknown
necorns,	law re as bee 2 sho	Completed											24a. Was	an	24	4b. Were au	opsy findin	gs available
	The ate ha	Com											perfo 1 ☐ Yes	rmed? 2 N	0	death?	2 No	
N II G	icien: sertific ector,	Be	25. Was case referred to me examiner?	-	nenital:					Otho		of Death	(Check only	ne)				
5	Physi this c	. To	1 Yes No	, no	28a. Date	Inpatier		28b. Time		Othe 28c. Injury	4 🗆 Nu		ne 5 Resi 28d. Describe				ify)	
	ding th. After funer	tlon	1 Natural 5 □ P	nding restigation	(Moi	nth, Day	Year)	Injury	м .	Work	:? ′es 2 □ 1			1011	ury oo	ourrod		
UNISION	Atten r deal ector: by the	ertification;	3 ☐ Suicide 6 ☐ C	ould not be termined	28e. Plac	e of Inju	ry - At hor	me, farm, s	treet, factor	y, office			28f. Location (			ımber or Ru	ral Route N	umber,
5	rs after s aft	Cert			li .		. (Specify,			***			City or To					
	he Hospi n 24 hou he Funer pletely fill	edical	29a. Certifier 1 Certifier 2 Med	ifying Phys ical Examin	ician: To the ter: On the terms	pasis of	examinati	vledge, dea ion and/or i	th occurred nvestigation	at the tim , in my op	e, date and pinion, deat	d place, a	and due to the ed at the time,	cause( date ar	s) and nd plac	l manner as ce, and due	stated. to the caus	e(s)
	To t with. To t	Σ	29b. Signature and title of ce	tifier (	Ba	(4)	M	D	29	License 313	33	2		29d. D	ate sig	gned (Month	, Day, Year	r) a
	V		30 Name and address of per Ribert S	rson who cor	matered cau	se of de	ath (Item	23a) (Type	Print)	HIN	ST	301	RE	(S1	EK	25Tou	NM	d
ļ	Sta Registr		31. Date filed (Month, Day,	′ear)	32. I		r's Signat	ure L	Spor	Kr								
_			111.1	F 1 11 1 24	150		/											

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of	Maryland / Dep <i>Ce</i>	artment of F rtificate of	lealth an <i>Death</i>		giene Reg. No		39487
	Dhusis		1. Decedent's Name (First, Middle, L	ast)				2. Date of De			3. Time of Death
	Physici /Medio		Erma C. Cecil						ber	y Year 9 <b>,</b> 2004	12:55 AM
	Examir		4a. Facility Name (If not institution, gi		er)	4b. City, Town, o	r Location of D	eath	4c.	County of Dea	th
			27 Farm Haven C			Rocky			. 1	Montgom	
	Funeral Director		219-74-9204	Sex 7. 1 ☐ M 2 🖾 F	Age (In yrs. last birthday, 95 Yrs.	Months Days	If Under 24 I Hours A	Hrs. 8. Date of Bir (Month, Da Oct. 5	th ly, Year) , 19	9. Bir Co Wash	thplace (State or Foreign ountry) nington, D.C.
	and **		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limits
	Aaryl Fsho	ō	Maryland Montgo	maru	, , , , , , , , , , , , , , , , , , ,	Rockvill	•				1 ☐ Yes 2 ☒ No
	tha h	Director	10e. Street and Number	omery		10f. Zip Code	<u> </u>	-	10a Cit	izen of What Co	
	with 3a or		27 Farm Haven Co	urt			20852		-		•
	ns 20	era	11. Marital Status	12. Was Decede	ent Ever in U.S. 13.	Was Decedent of H	ispanic Origin?	(Specify Yes or No		ted Sta	
21215-0036	parmit. Pages 1 and 2 should be filed within 72 hours after death with tha Maryland Department of Health and Mental Ptygiene. Important: If item 27 is marked other then "naturel", or Items 23a or 28e-f show any injury or other treumatic event, the Midfall Examinate institutional and once.	by Funeral	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Force 1 Tes 2 If Yes, Give Year or Date	es? ⊠No	If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:	uèrto Rican, etc.)		Black, Whit	
ŏ	2 hor	Completed	15. Decedent's E		16a. Dece	dent's Usual Occup	ation		16b. K	ind of Business	/Industry
215	within 7 ene. then "n	ple	(Specify only highest gi Elementary/Secondary (0-12)	ade completed) College (1-4	(Give	kind of work done of DO NOT use retired	during most of d)	working			,
2	e filed within al Hygiene. I other then '	Con	12			memaker			(	Own Home	е
nd	be filed ital Hygis id other event,	Be (	17. Father's Name (First, Middle, Las	1)		_	18. Mother's	Name (First, Middle,	Maiden	Sumame)	
<u>la</u>	should but Ment markac	2	Charles D'Andel	et			Mary	Esther M	lande	ers	
Maryland	2 should be and Mental is marked (		19a. Informant's Name/Relationship	• • • •				Rural Route Numbe			
	of Health of Health item 27 i		Beverly C. New/Da	ughter	27 Fa	rm Haven (	Court,	Rockville	, Ma	ryland	20852
ore	of H		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 [	Removal from Str	20b. Place of Dispo	osition <i>(Name of</i> matory or other plac Heaven	Dec	cember 13,	20c. Lo	cation - City or	Town, State
Ë	Pag ment ant: ury c		`4 □ Donation 5 □ Other (Spec		Cemeter		2	2004	Silv	er Spri	ng, Maryland
Baltimore,	parmit. Pages. Department of F Important: If ite any injury or of		21. Signature of Funeral Service/Lice	nsee	M00198 R	Name and Address Obert A. 57 Wiscons	Pumphre Sin Ave	y Funeral , Bethesd	Hona, M	ne/ Cha	esda-Chevy ase, Inc. -3501
			23a. Part1. Enter the disease, or conshock, or theart failure. List only	plications that cau one cause on eac							Approximate Interval Between Onset and Death
	Physician	ÌΨ	Immediate Cause (Final disease or condition	a. Rena	1 Failure						4 months
	/Medical Examiner		resulting in death)		as a consequence of):						
	LAGIIIIICI	_	Sequentially list conditions.	b	inoma of the	e Breast					4 months
	sit sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	in the second	as a consequence of): inoma of the	- T74					, , ,
_	and and I-trar	хап	that initiated events resulting in death) Last	C	as a consequence of):	eoterus			_		4 months
8760,	icate be axecuted physician and s the burial-transit	a E		Anem							4 months
387		dical		d				<u></u>			· monens
Вох б	cartif nding use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		23d. Date of d  1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown						,
o.	0 0 0	ysic	1 Yes 2 X No 9 Unknown								Day Year
s, D	de de	by PI	Part II. Other significant conditions	contributing to deat	n but not resulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco u	se contribute to	the cause of death?
ds	quires n signe ald be							1 □ Y	es 20	XNo 3□Pr	obably 4 Dunknown
Record	s been s should	Completed						24a. Was	an	24b. Were au	topsy findings available
Be	The lavate has	mo						<ul><li>autop</li><li>perfor</li></ul>	sy med?	prior to death?	completion of cause of
Vital	ician: Th certificate ector, pag	Be C	25. Was case referred to medical				26 Place of F	1 ☐ Yes Death (Check only of	2 🔀 No	1 Ll Yes	2□ No
	di S	0	examiner? 1 □ Yes 2 🛣 No	Hospital:	atient 2 ER/Outpatier	nt 3 DOA Othe	NP!	g Home 5K Resid		Other (Spec	rifu)
Division of	무 무 등	n:	27. Manner of Death	28a. Date of I	njury 28b. Time o		at	28d. Describe h			only)
0	Attending r death. actor: After by the funer	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	n	Day Year) Injury		r ∕es 2⊟No				
<u> </u>	I or Attendate death	ertification;	3 ☐ Suicide 6 ☐ Could not to determined	286. Place of	Injury - At home, farm, str etc. (Specify)	eet, factory, office		28f. Location (S City or Tow			ral Route Number,
٥	tel or A	Cer		building,	etc. (Opecny)			City of You	n, state)		
	To the Hospitel or Atten within 24 hours after deat To the Funerel Diractor: completely filled in by the	edical	29a. Certifier (Check only one) 1 ☑ Certifying P 2 ☐ Madical Exa	nysician: To the be miner: On the basis and manner	st of my knowledge, deatl of examination and/or in stated.	n occurred at the tim vestigation, in my op	e, date and pla pinion, death or	ace, and due to the courred at the time, o	ause(s) date and	and manner as place, and due	stated. to the cause(s)
	To t To tl	W	29b. Signature and title of certifier	0 11	. 21	29c. License	number	2	29d. Date	signed (Month	n, Day, Year)
			1 ///	2/	rollo a	D0040	0203		Dece	mber 9,	2004
	10		30. Name and address of person who	completed cause of	f death (Item 23a) (Type,	Print)					
			William E. Battle	, M.D.	5530 Wiscons	in Avenue	#750 <b>,</b>	Chevy Ch	ase,	Maryla	nd 20815
	Sta	-	31. Date filed (Month, Day, Year) 4	32 Bani	rar's Signature	Spar					
	Registr	ar	DEG I -		/	1					

State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician December 2004 7:20a Norena M. Dotson /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Glen Burnie 286 Thompson Ave. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Days Hours Min. (Month, Dey, Year) March 22, 1 Birthplece (State or Foreign Country)
 PA 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🖸 F Ï945 Director 59 215-44-1326 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits show ed other than "natural, or items 23a or 28a-f shov event, the Misdical Experient must be notified at 1 ☐ Yes 2 No Anne Arundel Directo Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 USA 286 Thompson Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 72 hours after 1 Never Married 3 Married Maryland 21215-0036 **Black** 1□Yes 2€ No Specify: Black <u>ک</u> 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4or 5+) University of Maryland 12 Administration 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be fi and Mental F Jessie Cook Craig Whitlock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, s 1 and 2 s of Health an 286 Thompson Ave. Glen Burnie, Maryland 21061 David Dotson- Husband Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of A. Peges 1
artment of H
ortent: If ite 20c. Location - City or Town, State Baltimore Crematory of other place)
Baltimore Crematory
@ Loudon Park 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Department Importent: If any injury o 4 Donation 5 Other (Specify) Dec. 10, 2004Baltimore Maryland 21. Signatury of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 Part . Enter the disease, or complications that a sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of ach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pancreatic Cancer 18 Months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, b. Due to (or as a consequence of): Examine d any, leading to introdic cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last and I-transit Due to (or as a consequence of): use as the burial-Box 68760, physicien certificate be Physician/Medical the attending IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 | Fetel death 3 Ectopic pregnancy į in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 25 No P.0. detached signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed need The law 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? page certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No Physician: funeral director. Be 25. Was case referred to medical 26. Place of Death Check on one Hospital: 1 Inpatient examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2(5) No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ol or Attending Patter death. Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospitel within 24 hours at To the Funeral D per 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David A. Van Echo, M.D., 22 S. Greene St., Baltimore, MD. 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			1- State of Maryland / Department of Health and Per me G838 12-17-04 tas Certificate of Death		е́ре́() () ц 39489					
	Physicia	an	Proceedent's Name (First, Middle, Last)	2. Date of Death	3. Time of Death					
	/Medic Examin	al	4a. Facility Name (If not institution, give street and number)  3315 Liberty Heights Avenue #D12  4b. City, Town, or Location of Dea Baltimore	December	12, 2004   1225p M					
			3315 Liberty Heights Avenue #D12 Baltimore  5. Social Security, Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs	8 Date of Birth	9. Birthplace (State or Foreign					
H	Funeral Director		577-54-8373 10 M 20 F 62 Yrs. Months Days Hours Min	8. Date of Birth Month, Day,	1942 Wash. D.C.					
	yland how		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits					
	the Ma 28e-1 s	ectol	MD NIA Baltimore  10e. Street and Number 10f. Zip Code	10	1 (☐ Yes 2 ☐ No					
	23a or	ral Di	3315 Liberty Heights Ave \$12 21215		ISA					
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other then "naturel", or Items 23a or 28e-f show or other treumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Drovorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer of Dates:  13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer of Dates)  14. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer of Dates)	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black					
21215-0036	in 72 ho "natur edical	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired)	orking 1	6b. Kind of Business/Industry					
	ed withi ygjene. ner ther	Comp	Hermaniary/Secondary (0-12)  Tyrs. Environmental Mana	ger 1	Manufacturer					
land	s should be filed within and Mental Hygiene. Is marked other then sumatic event, the Wa	To Be	17. Father's Name (First, Middle, Last) Pierce Da Venart JR.  18. Mother's Na Minnie	me (First, Middle, M	aiden Sumame) IN FGOMEYV					
Maryland	12 shour and M	_	19a. Informant's Name/Relationship ( <i>Type, Print</i> )  19b. Mailing Address ( <i>Street and Number or R</i>	ural Route Number,	birth and someth					
	permit. Pages 1 and 2 Department of Health Importent: If item 27 I eny injury or other tre once.		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 2	Oc. Location - City or Town, State					
Baltimore,	Part ury		1 Burial 2 Cremation 3 Removal from State  '4 Donation 5 Other (Specify)  21. Signature of Specify Licent 22. National Mem. PR. 12.	17-04 L	gurel, Mb					
Bal	permit. Departr Importe eny inji		2. Signature of the first of the state of th	TASS BAL	TIMEN MD, 21229					
-	Physician /Medical		shock, or heart failure. List only one cause on each line.  Immediate Cadse (Final disease or condition resulting in death)  a. Hypertensive Brenas Lentic Carresulting in death)	diological	Approximate Interval Between Onset and Death					
	Examiner	١.	Duelt (or as a consequence of):  Sequentially list conditions.  b.							
<u>(.</u>	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	see to to as a solidequation of).						
68760,	tificate be executed in physician and as the burial-transit	edical Exa	resulting in death) Last  Due to (or as a consequence of):							
	ertificat ding phy se as the		IF FEMALE: 23c. If yes, outcome of pregnancy							
P.O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burral-transit	Physiclan/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If Yes, Outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		23d. Date of delivery Month Day Year					
	w requires that s been signed t should be det	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?					
Records,	law requ as been 2 should	Completed by	Lever lisoslar	24a. Was an	24b. Were autopsy findings available					
al Re				autopsy perform Yes 2	ed? death?					
of Vital	Physicien: Th this certificate ral director, pag	To Be	examiner?	ath <i>(Check only one</i> Home 5□ Resider	nce 6XIOther (Specifyat Scene					
o uo	ding Ph h. After th funeral		27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work? 28c. Injury at Work?	28d. Describe how						
Division	To the Hospital or Attending I within 24 hours after death.  To the Funerel Director; After completely filled in by the funer	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined 4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stre City or Town,	eet and Number or Rural Route Number, State)					
	ne Hospit n 24 hour ne Funere	Medical C	29a. Certifier  (Check only one)  1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 ☑ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 ☑ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 ☑ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 ☑ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 ☑ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 ☑ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 ☑ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 ☑ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and the basis of examination and occurred at the time, date and the basis of examination and occurred at the time, date and the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examinat	e, and due to the cau urred at the time, dat	use(s) and manner as stated. te and place, and due to the cause(s)					
	To the within To the comp	ž	29b. Signiture and title occertifier 29c. License number OCME		d. Date signed (Month, Day, Year) December 13, 2004					
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		·					
	/() Sta	te_	31. Date filed (Month, Day, Year)  32. Registrar's Signature	et paitim	ore MD 71701					
	Registr		DEC 1 4 2004 Genera & Sparks							

Amend item#5, perFH, C839, 1/3/05 TT State of Maryland / Department of Health and Mental Hygien? (1) For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 430 **Physician** December /Medical 4c. County of Death 4a: Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner tal FIMORE General Maryland Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) 07-04-1920 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. 1□ M 2 F Months Davs Hours Virginia 212-18-4942 84 Director 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 XYes 2 □ No Director Baltimore NA 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21213 **IISA** 3219 Dudley Avenue Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Specify: Specify: 3 XWidowed 4 ☐ Divorced **Black** 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Aide Health 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unknown Be Mary Wright 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kim C. Davis/ Granddaughter 3219 Dudley Avenue Baltimore, MD 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, Stete Department of Himportant: If its sny injury or ot once. 1 Buriai 2 □ Cremation 3 □ Removal from State 12-17-04 Baltimore, MD Arbutus Memorial Park \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Septice License 22. Name and Address of Facility Wylie Funeral Home 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one seuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Cualto (or as a consequence of) Due to (or as-d consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Tes 2 No 3 Probably 24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 No Inpatient Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Peath 1 Natural 2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, streel, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation in the cause (s) and manner as stated. Medical (Check only Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Sign sture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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other traumatic event, the Medical Examiner must be notified at

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The law requires that the death certificate be executed

P.O. Box 68760

Division of Vital Records,

or Attanding Physician:

To the Hospital

Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. snt: If itsm 27 is marked other then "naturel", or Iter

Baltimore, Maryland 21215-0036

31. Date filed (Mointh, Day, Year)

NFC 1 4 State Registrar

30 Name and address of person who comp

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 39491 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year Margaret Elizabeth D'Anna Dec 8: 45 AM 1.3 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death **Examiner** 1421 Cape St. Claire Road Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☐ M 2 🖾 F Months Days Yrs. 217-26-5351 Director 85 July 12,1919 Maryland Usual Residence of Decedent with the Maryland 10b. County 10c. City. Town or Location r than "natural", or itams 23a or 28a-f show the Medical Examinar must be notified at 10d. Inside City Limits Director 1 ☐Yes 2X No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1421 Cape St. Claire Road 21401 death v U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 ☑ Widowed 4 □ Divorced Specify: Year or Dates: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0·12) 12 College (1-4or 5+) Clerk Social Security permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If item 27 is marked othany injury or other traumatic avant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank E. Horwath Elizabeth Wargo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald F. D'Anna 1421 Cape St. Claire Road Annapolis, Maryland 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ₺ Burial 2 □ Cremation 3 □ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery | 12-17-2004 Baltimore, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician DEMENTIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine burial-transit and that initiated events resulting in death) Last certificate be exec Due to (or as a consequence of): P.O. Box 68760 the attending physician Physiclan/Medical the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) per 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ AILURE 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes No 24b. Were autopsy findings available prior to completion of cause of death? has 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Other: 4 Nursing Home Sesidence 6 Other (Specify) P this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury Medical Certification: 28d. Describe how injury occurred After 1 Natural
2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No s after death
ii Diractor: / 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only опе) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ec 13, 2004 D57531 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8601 Negr MILLETTILLE MD 21108 Vetera 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 4 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 004 39492 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 2004 December 4:10p. Sigmond Davis /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 3006 Beverly Road Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 €M 2 □ F Yrs. NĆ Director 82 246-14-6001 Usual Residence of Decedent 10a. State 10b. Count 10c, City, Town or Location 10d. Inside City Limits or Items 23a or 28a-f show the extra structure to the continue of the continue Yes 2 No MD Baltimore Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21214 U.S.A. 3006 Beverly Road Pages 1 and 2 should be filed within 72 hours after death Funera 12. Was Decedent Ever in U.S. Armed Forces?

↑ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 7 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 6th grade Machinist Social Security Adm 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Easter Waters Hosea Davis Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Patrice Powell-Daughter 6602 Elerbe Drive, Balto, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of P Important: If ite any injury or of once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) Garrison Forest Vet. 12/16/04 Owings Mills, Md 21. Signature # Funeral Service Licenses 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md P. t1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ediate Cause (Final Respiratory Distress Physician one hour decase or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 1 Yes 2 No 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 Yes 2 No 3 Probably 4 Unknown Completed Cardiovascular collapse 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 1 No certificate 1 Tes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manger of Death 28d. Describe how injury occurred After 1. Natural investigation 1 ☐ Yes 2 ☐ No Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) within 2 the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Haun Deillonm D 0058860 DECEMBER 9, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTO, MI) SUITE 555 CALVERT ST DHILLON MO 3333 21218 31. Date filed (Month, Day, Year) 32. Registrar's Signature Gamer DEC 1 4 2004 Registrar

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		For State	State of Marylar  M #12 PER	nd / Departme				2004	39493
Physici /Medi Examir	cal	1. Desedent's Name (First, Middle, Last)  Kobert  4a. Facility Name (If not institution, give st		Dani			mber	Z ZOO	14 5:55 m
Funeral Director		5. Social Security Number 6 Sex	M 20 F 7. Age (In yrs.	uded Gre	Sa(	HIMOYE	of Birth	9. Bi	/A rthplace (State or Foreign country) CAROLINA
.0036 hours atter death with the Maryland turat', or Items 23e or 28a-f ehow at Examination at	il Director	10a. State 10b. County  MD N/A  10e. Street and Number  817 HOMESTEAD STREE	BAL		Zip Code			itizen of What C	10d. Inside City Limits 1 Yes 2 □ No lountry?
1215-0036 within 72 hours after death with the Marylan ane. then "natural", or Items 23e or 28e-1 show a Medical Evaninar must be indified at	ed by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1					14. Race - Am Black, Whi	ite, etc.
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e, 1 an Heal Heal ther	-	19a. Informant's Name/Relationship (Typp BEVERLY LONG (DAUGH) 20a. Method of Disposition 1XI Burial 2 Cremation 3 Rel	PER)		ss (Street and Number LEY LANE AP	or Rural Route N  T 3A BAI	TIMOR		LAND 21206
Baltimore, permit. Pages 1 ar Department of Hee Important: If item any injury or othe		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service ☐ See	CRO	WNSVILLE V 22. Name 1412	VETERAN CEM and Address of Facility E. PRESTON	ETERY CALVIN STREET B	CROW B. SCI ALTIMO	WNSVILLE RUGGS FU	E, MARYLAND JNERAL HOME RYLAND 21213
/60, le be executed /Medical /Wedican and special transit	cai Examiner	23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Coronar Die to (or as a conseq Hyper for	unce of): ension unnee of):	Y Diseas		ry arrest,		Approximate Interval Between Onset and Death Q Y PQ VS
	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	:. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	death 3 Ectopic				23d. Date of del Month	ivery Day Year
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on or ding Phys	٥	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	spital: 1 Inpatient 2 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 C 28b. Time of Injury M	04	ng Home 5 🗆 F 28d. Descri			cify)
To the Hospitel or Attance within 24 hours after death To the Funeral Director: completely filled in by the	ical Certification;	29a. Certifier 1 Certifying Physic	28e. Place of Injury - At ho building, etc. (Specify ian: To the best of my know: On the basis of examinat and manner stated.)	wledge death occurre	1 at the time, date and r	City or	Town, State	) 	stated.
To tha I within 2. To tha I complete	Medical	29b. Signature and title of certifier	and manner stated.  Miles of death (Item	29	c. License number		29d. Dat	e signed (Month	
Stat Registra	_	31. Date filed (Month Day, Year) 4 20	32. Registrar's Signat	ure	or Green	e Stri	eet,	Balt	imore

State of Maryland / Department of Health and Mental Hygien () 39494 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** EUGENE, LEWIS, DIXON DEC 00:33 A M 10 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 204-32-6982 PENNSYLVANIA Director MAY 21, 1941 63 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show other traumatic event, the Medical Examinist must be notified at 1 ☐ Yes 2 X No ROCKVILLE MARYLAND MONTGOMERY 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ā Itema 23a 20851 UNITED STATES 1623 FARRAGUT AVENUE by Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12, Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after 1 ☑ Yes 2 ☐ No If Yes, Give 1 ☐ Never Married 2 M Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1962-1966 WHITE "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) PLANT OPERATOR MILITARY HOSPITAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be item 27 Is marked o 2 ERMA LOUISE LEWIS WILLIAM CLIFFORD DIXON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1623 FARRAGUT AVENUE ROCKVILLE, MARYLAND 20851 RUTH S. DIXON/ WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place)
PARKLAWN
MEMORIAL PARK 20c. Location - City or Town, State 20a. Method of Disposition PARKLAWN PARK 13, 2004

22. Name and Address of FacilityROBERT A.
BETHESDA-CHEVY CHASE, INC.
MOO335 BETHESDA, MARYLAND 20814-1 N Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or 4 □Donation 5 □ Other (Specify) ROCKVILLE, MARYLAND PUMPHREY FUNERAL C. 7557 WISCONSIN 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIAC TAMPONDE Priysician resulting in death) /Medical Due to (or as a consequence of): Examiner COAGULOPATHY Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or injury Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-transit Exami CARDIOMYOPATHY that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 Other (specify) signed by the a ☐Yes 2☐No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 20 No certificate 1 🗌 Yəs Division of Vital Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Anpatient 2 EP/Outpatient 3 DOA 1 XYes 2 No 2 funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending s after dea. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the Medical 29a. Certifier On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. To the I 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 0101102682 (VA) anu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RONNIE L. GARCIA LCDR MC USN NATIONAL NAVAL MEDICAL CENTER

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

DEC 1 4 2004

32. Registrar's Signature

BETHESDA MD 20889-5600

	•	1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of He	ealth and Me Death	ntal Hygier		39495
Physici /Medic Examin	al	1. Decedent's Name (First, Middle, La 1. Decedent's Name (First, Middle, La 4a. Facility Name (If not institution, giv	M	Ed	MONDS 4b. City, Town, or J	Dec	Date of Death Month	Day Agary	3. Time of Death A
Funeral Director	CI	Mercy Wadi 5. Social Security Number 6. S	cal Cen	e (In yrs. last birthday,	Bolf  If Under 1 Year  Months Days	If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Yea	CH	olece (State or Foreign htry)  Md.
Maryland	tor	Usual Residence of Decedent  10a. State 10b. County  Md .	NA	10c. City, Town or L				1	0d. Inside City Limits
with the 3a or 28e	Funeral Director	10e. Street and Number 1400 E. Madison	Street A	pt. 704	10f. Zip Code 21205		10g. (	Citizen of What Cour	itry?
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other than "neturel", or Items 23a or 28e-1 show other treumatic event, the Medical Examiner must be notified at	þ	11. Marital Status  1 □ Never Married 2 □ Married 3 ▼ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1  Yes 2  If Yes, Give X Year or Dates:	Ever in U.S. 13.	Was Decedent of His If Yes, specify Cuban	spanic Origin? (Specif , Mexican, Puerto Ric Specify:	y Yes or No- an, etc.)	14. Race - Americ Black, White, Specify: Bla	etc.
21215-0 ad within 72 hc gjene. er than "netui	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 7th grade	ducation ade completed) College (1-4or 5	5+) (Give	dent's Usual Occupat e kind of work done du DO NOT use retired)	tion uring most of working		Kind of Business/Ind	,
laryland 21215-0036 2 should be filed within 72 hours aft and Mental Hygiene. Is marked other than "neturel", or eumatic event, the Medical Exam	To Be (	<ul> <li>17. Father's Name (First, Middle, Last</li> <li>Wilson</li> <li>19a. Informant's Name/Relationship (</li> </ul>		Walker 19b. Mail		18. Mother's Name (F  Cora  nd Number or Rural R	First, Middle, Maide	en Sumame) Thom	as
altimore, M mit. Pages 1 and 2 partiment of Health portent: If tiem 27 1 y injury or other tre ce.		Cloria Bailey  20a. Method of Disposition  1X Burial 2 Cremation 3 Control (Special Control		20b. Place of Disp	matory or other place	Date		. 112 Location - City or To	own, State
Baltmo		21. Sonature of Funeral Service Lice	2. Wal	thongs?	2. Name and Address March F.H	s of Facility E . East	Baltimore 1101 E.		202
ficate be executed    Medical	dical Examiner	23a. Pa 1. Enter the disease, or come so come of come	a. Due to (or as	a consequence of):  a consequence of):  a consequence of):	Tachyci	arolia	ich w		Approximate Interval Between Onset and Death
the death certiful to the death certiful to the attending iched for use a	Completed by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 Mento 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetel death 3	Ectopic pregnancy Other (specify)	*		23d. Date of delive Month	ery Day Year
ecords, P. law requires that as been signed b	ed by Pl	Part II. Other significent conditions of Pourphual Van	contributing to death b	ut not resulting in the c	ınderlying cause giver	n in Part I.	23e. Did tobacco	use contribute to the	
		Dables Ronol Fail 25. Was case referred to medical	uve				24a. Was an autopsy performed? 1 ☐ Yes 2	death?	psy findings available inpletion of cause of
this aldi	atlon; To Be	examiner?  1 Yes 2 Yolo  27. Manner of Death 1 Yorkatural 5 Pending 2 Accident investigation		ry 28b. Time o	of 28c Injury a	26. Place of Death (C 4 \( \) Nursing Home at 28d es 2 \( \) No			9
Division ( To the Hospitel or Attending is within 24 hours after death. To the Funerel Director: After completely filled in by the funer.	Certification;	3 Suicide 6 Could not b	building, et				City or Town, Sta		
the Hosp hin 24 hou the Fune npletely fil	Medical	one) 2 Medical Exam	niner: On the basis of and manner sta	of my knowledge, deal f examination and/or in ated.	ivestigation, in my opi	nion, death occurred	at the time, date a	nd place, and due to	the cause(s)
To To Son		29b. Signature and title of certifier  30. Name and address of person who	completed use for	leath I= m 23a) (Type	29c. License	744 301	De Son Par	eate signed (Month, I CONDON LL PO	8,204 rce
Sta Registr		31. Date filed (Month, Day, Year)  NFC 1 4 2	32. Registr.	Y MOUG ars Signature &	Sports	N B	2 (Bruck)	y Med.	2/202_

DHMH 17 Rev 1/2001

		•	For State Registrar	State of M		artment of F rtificate of		and Mental Hyg	gier <b>@</b> () () leg. No.	lļ,	39496
	Discosted		1. Decedent's Name (First, Middle, Las	t)				2. Date of Dea Month	th Day	Yeer	3. Time of Death
	Physici /Medio			Euler				December	09 20	04	00:13 A M
	Examir	er	4e. Fecility Name (If not institution, give			4b. City, Town, o		f Death	4c. County		
			Carroll County Ho		- de la latit de la	Westmins		24 Hrs. D. D	Carr		(0)
	Funeral		5. Social Security Number 6. Security Number 213-52-7732	744 00 5	ge (In yrs. last birthday) 54 Yrs.	Months Days	Hours	Min. (Month, Day	, Year)	Count	
	Director		Usual Residence of Decedent		74			June 07,	1930	Maryl	and
	yland		10a. State 10b. County		10c. City, Town or Lo	cation				10	d. Inside City Limits
	Mar arised	tor	MD Carroll		Finksburg						1 ☐ Yes 2 ☐ No
	or 28	lre	10e. Street and Number			10f. Zip Code			log. Citizen of W	Vhat Count	ry?
	be filed within 72 hours after death with the Maryland ial Hygiene. d other then "natural", or Items 23e or 28e-f show event, the Medical Examera: must be notified at	Funeral Director	1912 Suffolk Road	1		21048	3		United		
	er dez	nue	11. Marital Status	12. Was Decedent Armed Forces?		Was Decedent of H If Yes, specify Cubi	lispanic Orig an, Mexican	gin? (Specify Yes or No- , Puerto Rican, etc.)		e - America k, White, e	
36	s afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 22☐ If Yes, Give Year or Dates:	No	1 ☐ Yes 240TXNo	Specify:		Specify:	Whi	te
8	hour tural	edb	15. Decedent's Ed		16a Dece	dent's Usual Occup	ation		16b. Kind of Bu	siness/Indu	ıstrv
15	n ne	plet	(Specify only highest gra-	de completed)	(Give	kind of work done DO NOT use retired	during most	of working			20119
212	Jiene giene	Completed	Elementary/Secondary (0-12)	College (1-4or 4		cal Super	visor		Petro1	eum	
ğ	e filed of he vent,	Bec	17. Father's Name (First, Middle, Last)				18. Mothe	r's Name (First, Middle,	Maiden Sumami	θ)	
lar	should by	Tof	William E. Eule	r, Sr.			LaVe	rne Lynn			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23s or 28s -f show any injury or other traumatic event, the Medical Evantinet must be notified as once.		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailii	ng Address (Street	and Numbe	r or Rural Route Numbe	r, City or Town,	State, Zip (	Code)
	and and and and and and and and and and		Mrs. Charmaine Eu	ler	1912	Suffolk	Road,	Finksburg.	Maryla	nd 2	1048
ore	of H		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □	Removal from State	1	natory`or other plac		Date	20c. Location - (	City or Tow	m, State
Baltimore,	Pag Iment Ient: jury o		' 4 □Donation 5 □ Other (Specify	)	Woodlawn				Woodlaw		•
3all	permit. Departitimporte		21. Signature of Funeral Service Licen	500				Loring By			
	00 F e d		Call Mills	2				ad, Randall	···	<del></del>	
	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. ASC (	a consequence of):	er the mode of dylr	ng, such as o	cardiac or respiratory arr	est,	1	Approximate Interval Between Onset and Death LINU(ES
	Examiner	ner	Sequentially list conditions, I amy learning to immunocate cause. Enter Underlying	b. Dualto (or an	a nonsequence of):	- <u> </u>					
Vil	cate be executed  ohysician and  the burial-transii	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence of):						
8760,	cate be e. ohysician the buria	dical		d						j lega	
9	entific ling p	0	IF FEMALE:	02- 11							
Vital Records, P.O. Box	Attending Physicien: The law requires that the death certific reath. reads. sctor: After this certificate has been signed by the attending for the funeral director, page 2 should be detached for use as	by Physician/M	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)	′		23d. Date Mon	e of delivery	√ Day Year
٦	res that iigned b	y Pł	Part II. Other significant conditions of	ontributing to death b	out not resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contri	ibute to the	cause of death?
rds	quire; n sign	d be						1 U Y	es 2□No	3 🗌 Probal	bly 42Unknown
8	aw requir 15 been si 2 should	Completed						24a. Was a	n 24b. W	Vere autops	sy findings available
Be	The law te has age 2	mo						autops perfor	med? de	eath?	pletion of cause of
ta	ysician: The is certificate hadirector, page	BeC	25. Was case referred to medical				26. Place	of Death (Check only or		163 2	
	Physici this cer al direc	To B	examiner?	Hospital: 1 ☐ Inpati	ent 2 ER/Outpatier	t 3 DOA Oth	er: 4 🗆 Nur	rsing Home 5 Resid	ence 6 Othe	or (Specify)	
Division of	nding Ph ath. r: After th	atlon:	27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	rry 28b. Time o Injury	Wor	yat k? Yes 2 □ N	28d. Describe h	ow injury occurre	ed	
Divis	in line	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	286. Place of in	jury - At home, farm, str c. (Specify)	eet, factory, office		28f. Location (S City or Town	treet and Numbe n, State)	er or Rural i	Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifying Ph (Check only one)	ysician: To the best iner: On the basis of and manner st	if examination and/or in	n occurred at the tirvestigation, in my o	ne, date and pinion, deat	d place, and due to the c h occurred at the time, d	ause(s) and mar ate and place, a	nner as stat ind due to t	ted. he cause(s)
	To 1 Vith To 1	Σ	29b. Signature and title of certifier	rlue	70	29c. Licens		RJ Mar	9d. Date signed		
	ř				death (Item 23a) (Type,	Print)	. 1	0 1 111	1	1	
	Sta		Merbert 1- Mendet 31. Date filed (Month, Day, Year)		WI 2973 Par's Signature	manche	5 487	ICU VVIQU	icnes'	19/	MO 2110
	318	TE.	///	4	-	A					

State Registrar

			1 - For State Registrer	State of Maryland / De	epartment of Health ar Certificate of Death	nd Mental Hygie	Z 11 11 IA	39497
	Physic		Decedent's Name (First, Middle, Last)	C	- 2	2. Date of Death Month	Day Year	3. Time of Death
	/Medi Exami		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of D	Death Dec 1	4c. County of Deat	3:30A.M
			Gilchrist C	enter	Towson		BALTI	
г	Funeral Director		5. Social Security Number 6. Sec. 15 - 34 - 8104	7. Age (In yrs. last birtho	Months Dave House	Min. (Month, Day, Ye	9. Birti	thplace (State or Foreign ountry)
	D D		Usual Residence of Decedent			4-1-2	1 Ge	rmany.
	Maryla f shov	ō	10a. State 10b. County	MORE 10c. City, Town o	or Location			10d. Inside City Limits 1 ☐ Yes 2 No
	or 28a-	Director	10e. Street and Number	muke r	10f. Zip Code	10g.	Citizen of What Co	
	ath wit	raiD	4507 Hydes	Rd.	21082		USA	
	iter de	-une	11. Marital Status  1 □ Never Married 2 □ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No	<ol> <li>Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P</li> </ol>	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Amer Black, White	
21215-0036	hours after death with the Maryland tural', or Items 23a or 28a-f show al Evantinar must be rediffed at	Completed by Funeral	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: U	shite.
15-(	within 72 h ene. than "natu	jete	15. Decedent's Educ (Specify only highest grade	completed) (C	ecedent's Usual Occupation Give kind of work done during most of fe. DO NOT use retired)	working 16b	. Kind of Business/I	Industry
212	ad with giene. er thar	Comp	Elementary/Secondary (0-12)	College (1-40r5+)	memaker		at hor	X 0
and	be filed htal Hygid od other avant, t	Be	17. Father's Name (First, Middle, Last)		,	Name (First, Middle, Maid	ien Sumame)	<i></i>
Maryland	and Menis markers markers	٦	19a. Informant's Name/Relationship (Type	DURSTER 19h M	lailing Address (Street and Number o	na FRAN	K.	
	iges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If itam 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic avant, the Mycheal Examerment Iver or different		Karin E. Riou		07 Hydes M	Hudos AL	\$ 2108.	/p Code)
lore	Pages 1		20a. Method of Disposition 1 A Burial 2 □ Cremation 3 □ Re	emoval from State	isposition (Name of crematory or other place)		Location - City or T	
Baltimore,	Part and		* 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service LiCense	farkwo	22. Name and Address of Facility	2-13-04 B	ALTIMOR	E MO
Ba	permit. Departr Importu any inj		Finberly V.	2 molace	FUALLS FULL RAGING	HAPEL 880	IND 21	234
			23a. Part1. Enter the disease, or complice shock, or reart failure. List only on	ca io is that cau led the dilath. Do not cause on each line.	enter the mode of dying, such as care	diac or respiratory arrest,	J TIMBA CI	Approximate Interval Between
	Physician /Medical	i	Immediate Caus Final disease or condition resulting in death)	Rheumatic	heart dis	ease		Onset and Death
В	Examiner			Due to (or as a consequence of):				1
11	pe jis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):				
Λ. ι.	execut n and ial-tran	Examiner	that initiated events resulting in death) Last	Due to (or as a consequence of):				
8760,	cate be executed physician and the burial-transit	dicai	d.					
39 ×	entifica ding pt	/Med	IF FEMALE:	20.16				
Вох	that the death certificated by the attending podetached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliving Month	very Day Year
P. 0	at the	Phys	9 Unknown	9 Unknown				
ds,	se ug		Part II. Other significant conditions cont	ributing to death but not resulting in the	e underlying cause given in Part I.		o use contribute to t	
Records,	s been si should	jete				_ 1 ☐ Yes 24a. Was an		bably 4 Unknown
		Completed				autopsy performed?	prior to co death?	opsy findings available ompletion of cause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		Death (Check only one)		20110
ot	Phys r this ral di	n: To	27. Manner of Death	1 ☐ Inpatient 2 ☐ ER/Outpat	tient 3 DOA Uther: 4 Nursing a of 28c. Injury at Work?	g Home 5 Residence 28d. Describe how inj	6 Juther (Specifically occurred	rherice
Sion	Attanding F death. ctor: After y the funera	catio	Natural 5 Pending investigation	(Month, Day Year) Injur	y Work? M 1 ☐ Yes 2 ☐ No		2.7 00001100	
Division	or Attand after death Diractor: /	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rura te)	al Route Number,
_	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune.		29a. Certifier Check only 2 Medical Examine	cian: To the best of my knowledge, de	eath occurred at the time, date and pla	ace, and due to the cause(	s) and manner as a	stated
	Io tha Ho within 24 To tha Fi complete	Medical	one)	er: On the basis of examination and/or and manner stated.	investigation, in my opinion, death oc	ccurred at the time, date ar	nd place, and due to	the cause(s)
1	To wit		29b. Signature and title of certifier	1 ~1100	29c. License number		ate signed (Month,	
	0		30. Name and address of person who com	rpleted cause of death (Item 23a) (Typ	e, Print)			
	2		AAUN J. CH	HAPLIES (SO)	N, CHARLES S	FBILIM	our mo	£150A
	Stat Registra		31. Date filed (Month, Day, Year) <b>NFC 1 4</b> 2004	37 Registrar's Signature	mile			,

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Records,
of Vital
Division o

		Please 7	Type or Print in E	Black Ind	delible Ink	. Ensure All	Copies	Are Legible	e.	
		1 - For State Registrar	State of Marylan		artment of I tificate of			/ 11111	39498	
Physic	ian	Decedent's Name (First, Middle, Last	)		unoato or	Dodin	2. Date of Deat	eg. No.	3. Time of Death	
/Medi	cal	S0 4a. Facility Name (If not institution, give	NYA		EZRINE		lecembe	r 9 20		
Exami	ner	Ci. 11 .4		SHOME	Balt	or Location of Death	City	4c. County of E	N/A	
Funeral Director		5. Social Security Number 6. Se	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth OCMonth Day,	1 <sup>Y</sup> <b>0</b> <sup>2</sup> <b>2</b> )6	Birthplace (State or Foreign Country) MD	
		Usual Residence of Decedent					001.11,	1520	שויו	
with after death with the Marylan al., or Itams 23e or 28e-f show	tor		LTIMORE 1005. CIR	y, Town or Loc	cation	PIKESVILL	F		10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
ith the M. or 28a-f	Director	10e. Street and Number			10f. Zip Code	TINLSVILL		0g. Citizen of What		
leath w	Funeral	2 POMONA EAST #3	01 12. Was Decedent Ever in U.	0 10 10	Van Dansdani di	21208			USA	
after dea		1 Never Married 2 Married	Armed Forces? 1 □Yes 2 17 No			dispanic Origin? (Spean, Mexican, Puerto F	city Yes of No- lican, etc.)	14. Hace - A Black, W	merican Indian, /hite, etc.	
	ed by	3 🛱 Widowed 4 □ Divorced  15. Decedent's Edu	If Yes, Give Year or Dates:		☐ Yes 2 🕅 No ent's Usual Occup	Specify:		Specify:	WHITE	
d within 72 ho piene. r than "natu the Medical	Completed	(Specify only highest grade	College (1-4or 5+)	(Give k	kind of work done OO NOT use retired	ation during most of workin d)	g	16b. Kind of Busine	ess/Industry	
Hygier Hygier Ither th		17. Father's Name (First, Middle, Last)		HOMEMA	KER	19 Mathada Nasa	/par A	OWN HOME		
should be filed with nd Mental Hygiene. marked other tha imatic event, the	To Be	IRVING		SCHUST	ER	18. Mother's Name ROSE	(FIFST, MID <b>OIO</b> , N	faiden Sumame)	GERTZ	
2 8 8 1		19a. Informant's Name/Relationship (Ty ARNOLD FOREMAN /				and Number or Rural				
Heal Heal tem 2		20a. Method of Disposition	20b. P	lace of Dispos	ition (Name of	ROAD - BAI		, MD ZIZU		
Pages ment of tant: If it jury or c		1 X Burial 2 □ Cremation 3 □ R  '4 □ Donation 5 □ Other (Specify)	MOSE		EFIORE W	<sup>⊛)</sup> IOODMOOR 12		-	IMORE, MD	
permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service License	Punt /	22.	Name and Addres	ss of Facility SOL	LEVINSO	ON & BROS		
		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death	. Do not enter	TOO REIST rithe mode of dyin	ERSTOWN RO	OAD - P] respiratory arre	[KESVILLE st,	, MD 21208 Approximate	
Physician		Immediate Cause (Final disease or condition resulting in death)	_Acute	Ren	Val f	ailure			Interval Between Onset and Death	
/Medical Examiner			Due to (or as a consequence of the Police of		west.	40.40	6-2-6	>	2	
70 ==	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ience of):	meac !	henovy	may &		x weeks	
be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	Nary	1 Bnk	poli			2 Months	
icate be e physiciar s the buria		La	1+0111	OI	leus				2 weeks	
The law requires that the death certificate Late has been signed by the attending physic bage 2 should be detached for use as the b	Completed by Physician/Medical	IF FEMALE:								
death death	ician	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No	3c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3 □E	Ectopic pregnancy Other (specify)			23d. Date of o Month	lelivery Day Year	
that the death	Phys	9 Unknown	9□ Unknown							
faw requires that as been signed to 2 should be deta	d by	Part II. Other significant conditions con	tributing to death but not resul	Iting in the und	derlying cause give	en in Part I.	23e. Did toba	_	to the cause of death?  Probably 4 □Unknown	
e taw rec has bee je 2 shou	plete						24a. Was an		autopsy findings available completion of cause of	
n: The icate h r, page							autopsy performe 1 Yes 2	prior to death? DNo 1 □ Ye		
Physician: The tart this certificate has ral director, page 2	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	ospital: 1 Inpatient 2 E	R/Outpatient	3□ DOA Othe	26. Place of Death (				
ing Ph After th uneral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending		28b. Time of Injury	28c. Injury Work			injury occurred	ecity)	
Attend r death sctor: ,	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At hon	ne, farm, stree		/es 2 □No 28	Location (Stre	et and Number or I	Rural Route Number,	
vital or urs afte ral Dir		4   Homicide	building, etc. (Specify)				City or Town,	State)		
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, I	Medical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examin	ician: To the best of my know er: On the basis of examination and manner stated.	rledge, death o	occurred at the tim stigation, in my op	e, date and place, and inion, death occurred	d due to the cau at the time, date	se(s) and manner a e and place, and du	as stated. ue to the cause(s)	
To the within To the compl	Me	29b. Signature and title of certifier	- //	1.	29c. License	number	29d	I. Date signed (Mor	nth, Day, Year)	
j		Mus	pually		D	17803	D	ecembei	19,2004	
V		30. Name and address of person who con Warren Isvae	npleted cause of death (Item 2 L MD 241)	23a) (Type, Pri	elveder	re Ave	Battine	ore, MD	21215	
Star Registra	te	31. Date filed (Month, Day, Year) BEC 1 4 200	32. Registrar's Signatu	Ire A	4			,		
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**Funeral** 

Director

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permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neny injury or other treumatic event, Ite Med

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Examiner

/Medical

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after death Director:

within 24 hours a To the Funerel E

certificate be executed

P.O. Box 68760

Division of Vital Records,

Exactiner must be notified at

the Maryland

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie 1 1- State Amend Item 4b&Unpend Item 23a 27,28a-f per me G839 1-25-05 Reg. No. 39499 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death December 4, **Physician** 2004 1829 p м Robert F. Fuhrer, III /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner St. Agnes Hospital Baltimore If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1⊠M 2□F Yrs. 216-15-2437 21 Jan. 21,1983 Maryland Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County 10a State 1 ☐ Yes 2 No Director Maryland Howard Marriottsville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 12132 Deer Haven Road 21104 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 15 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 X Never Married 2 Married 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced White ieted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Compi Elementary/Secondary (0-12) Coltege (1-4or 5+) 12 Cook Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Robert F. Fuhrer, Jr. Deborah A. Peterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah A. Peterson (Mother) 12132 Deer Haven Road Marriottsville, MD 21104 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 12-14-04 Balto./Wash Crematory ¹ 4 □ Donation 5 □ Other (Specify) Laurel, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Witzke Funeral Home of Catonsville, Inc. M00869 1630 Edmondson Ave. Catonsville, Maryland 21228 er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each lise. Approximate Interval Between Onset and Death 23a Part 1. Er Immediate Cause (Final disease or condition resulting in death) Narcotic Intoxication Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (218-985) of it jury Due to (or as a consequence of): Examiner Cause (Disease of ir jur that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 X Yes 2 □ No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred unk Certification: 1 Natural Found 5:30 P 1 ☐ Yes 2 XNo 2 Accident investigation 12-4-04 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 13 Windhurst Way Catonsville, 14d 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Found at home 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier, 29c. License number 29d. Date signed (Month, Day, Year) OCME December 5, 2004

State Registrar

31. Date filed (Month, Day, Year)

MARGARITA

KORELL

DEC 1 3 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

WW

111Penn Street, Baltimore, MD 21201

State of Maryland / Department of Health and Mental Hygiene 0 0 4 39500 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2004 Ethel Marie Fleming December 8:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Timonium 112 Oakway Road Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Aug 16, 1918 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 ☐ M 2 [XF Yrs. Director 217-07-0623 86 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show treumatic event, the Medical Examiner must be notified at MD Baltimore Timonium Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 112 Oakway Road 21093 or Items 23a USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes, 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 and 2 should be filed within 72 hours after. Health and Mental Hygiene. em 27 is marked other then "neturel", or Itel Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2X No 3 Widowed 4 □ Divorced Specify: white Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Assessor's Office Baltimore County 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Terence Joseph Murphy, Sr. Anna Ryan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other trei once. 45 Kingsbury Place; St. Louis, MO 63112 Richard C.D. Fleming son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Deurial 2 Cremation 3 Removal from State Dulaney Valley Mem Gardens 12/15/04 \* 4 ☐ Donation 5 ☐ Other (Specify) Timonium, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 York Road R. H. But Ruck Towson Funeral Home Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician onge 5 resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Cause (Disease or injury attending physician and for use as the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months
1 Yes 2 No Month 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 90 1 ☐ Yes 2 ⊡ No 3 Probably 4 Donknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 ☐ Yes 24 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Desidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 1 ☐ Yes 2 ☐ M5 27. Manner Ceath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Latural 5 Pending s after dec. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗋 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours aft To the Funeral DI completely filled in Medical 29a Certifier 1 🖴 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier\_\_ 29c. License number 29d. Date signed (Month, Day, Year) breveno Ma 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) West Ro. Trusan viveine MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 1 4 2004 Registrar